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Wolff, J. R.: Illinois M. J. 105:6 (June) 1954.

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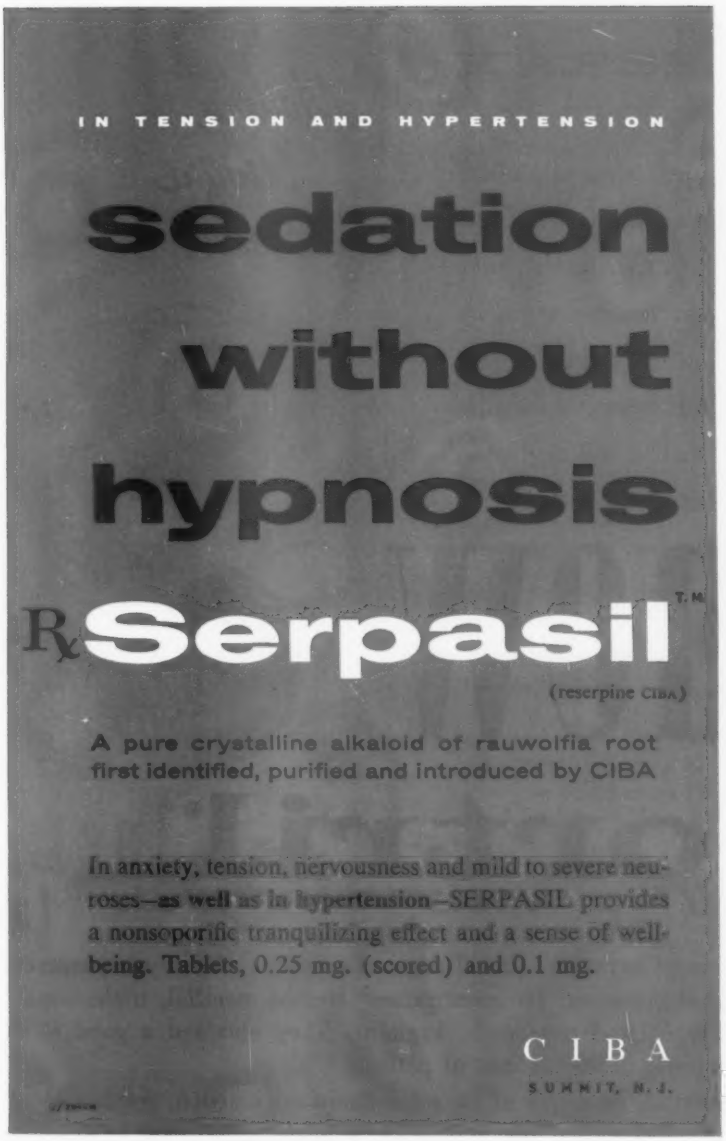
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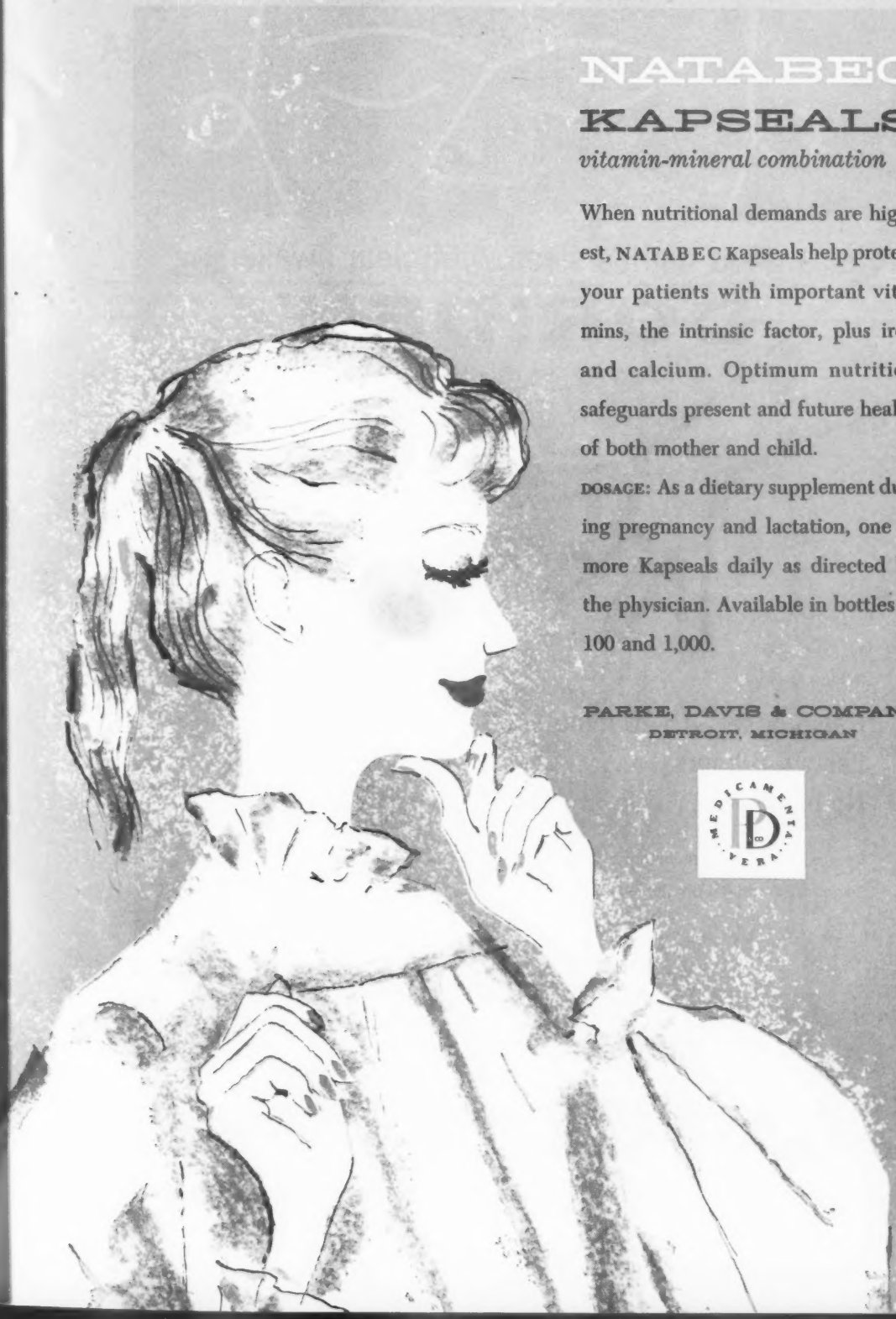

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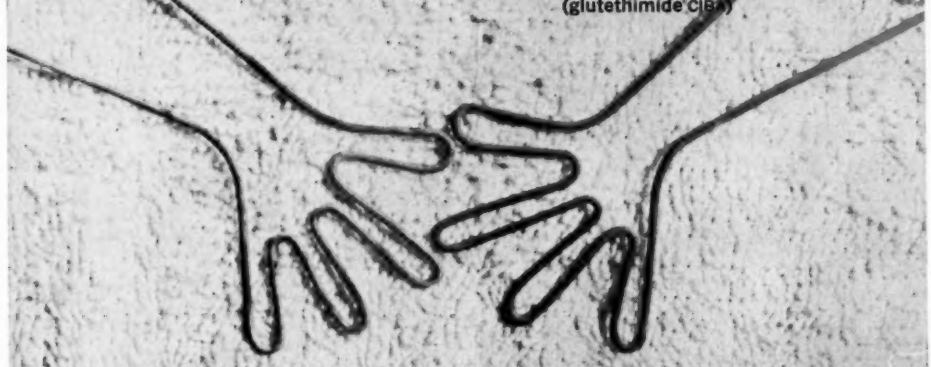

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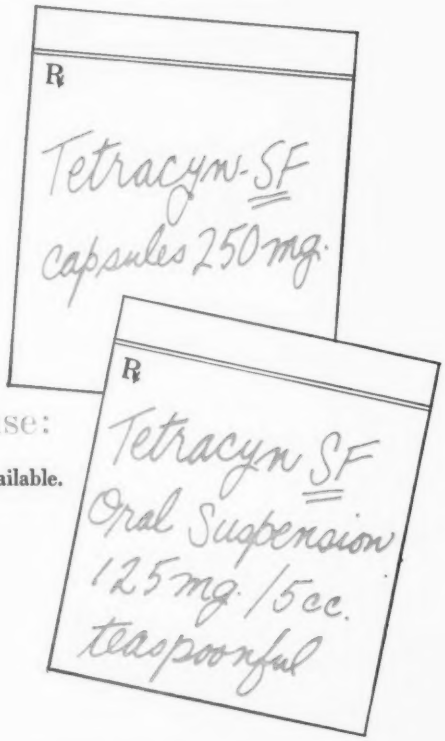

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1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952.
2. Martí-Ibáñez, F: Antibiotic Med. *1*:247 (May) 1955.
3. Dumas, K. J.; Carlozzi, M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955.

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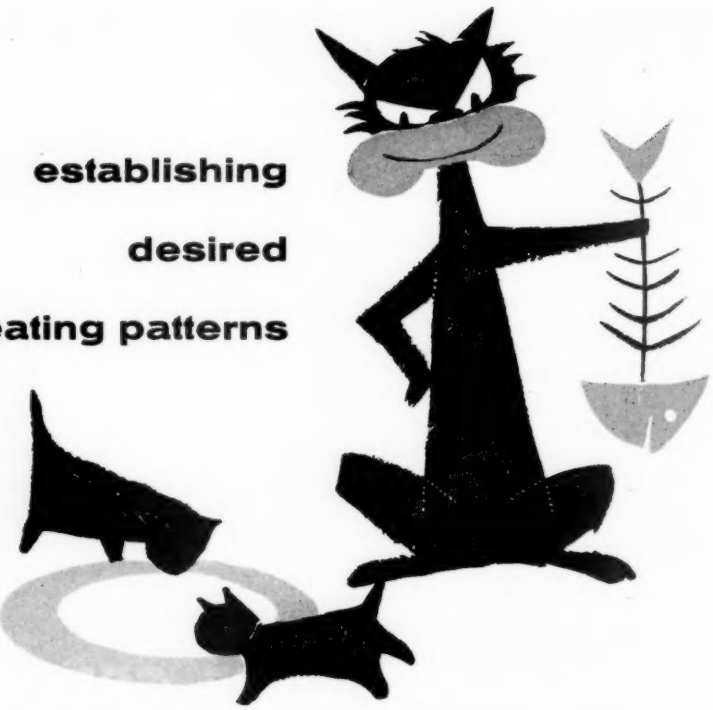

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1. Eisfelder, H. W.: Am. Pract. & Dig. Treat., 5:778 (Oct.) 1954.

2. Sebrell, W. H., Jr.: J.A.M.A., 152:42 (May) 1953.

3. Sherman, R. J., M.D.: Medical Times, 82:107 (Feb.) 1954.

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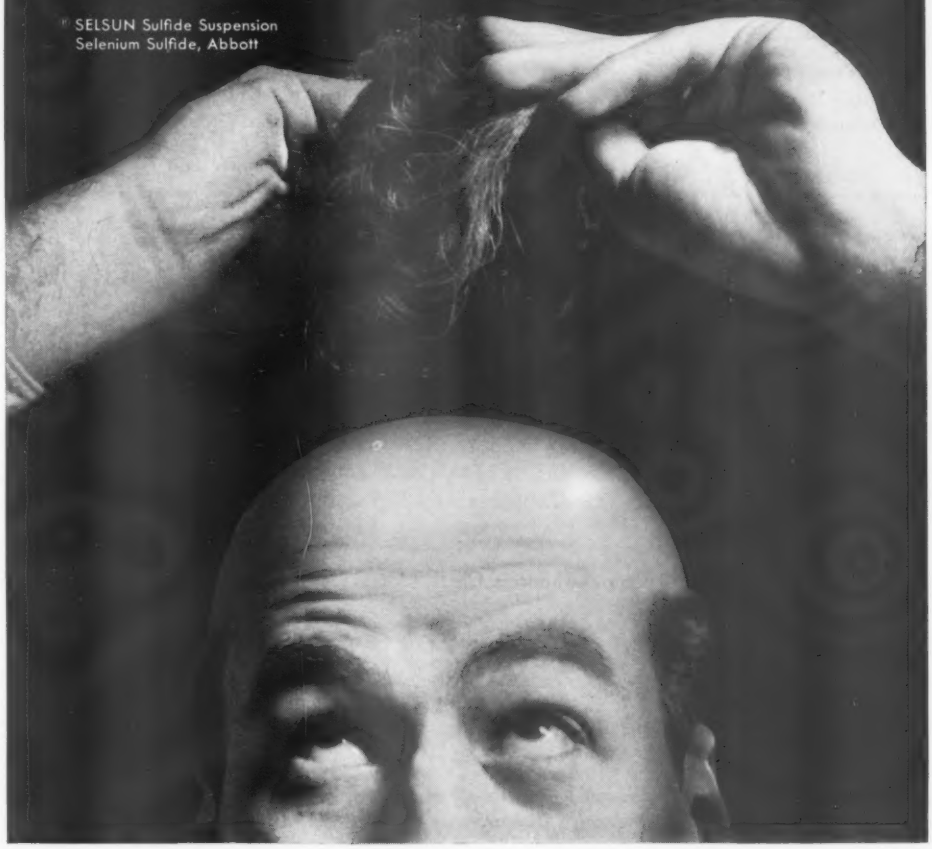

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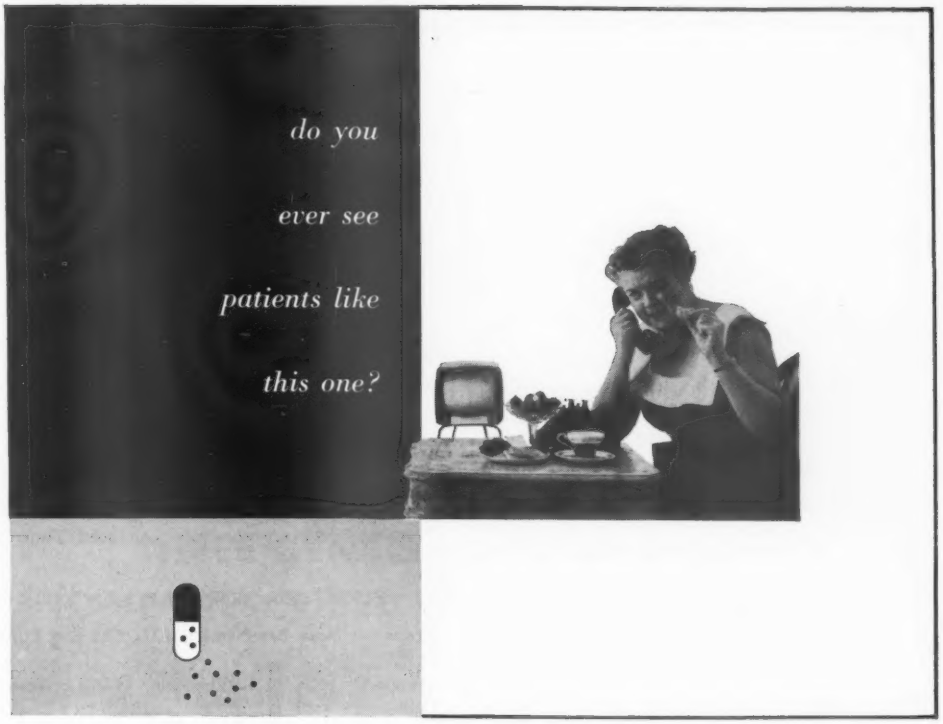

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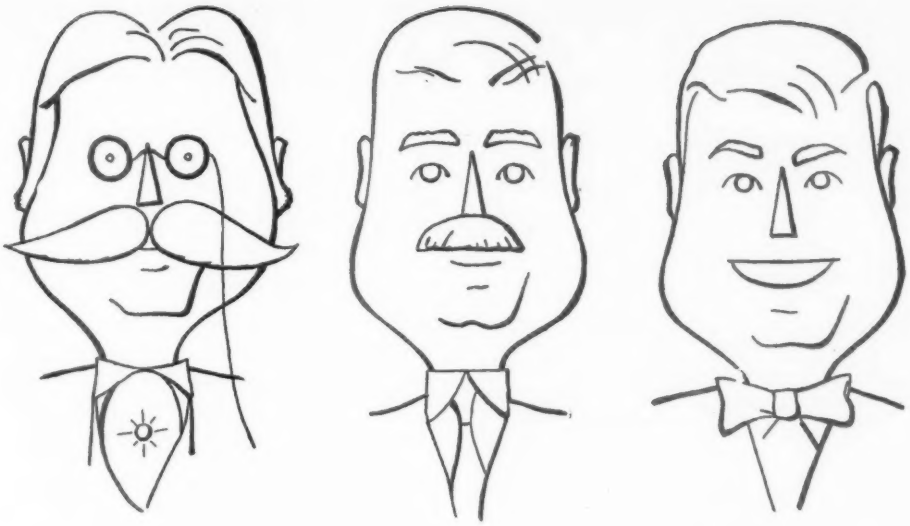
(Continued on page 22)



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prescription to fit the patient

No one method of conception control is applicable to all patients. For some, the "diaphragm-and-jelly" technic serves best, for others "jelly-alone" is adequate. Responsibility for selecting the more desirable of the two methods often rests solely with the physician. Not infrequently, if the patient is permitted to share in the decision, a higher degree of successful contraception will be attained.

From the physician's point of view: When the life and health of the patient depend upon prevention of pregnancy, the diaphragm-jelly method becomes first choice. If certain anatomic difficulties exist such as relaxed pelvic floor,[1,2] extensive cystocele,[1-3] extensive rectocele,[1-3] intact hymen,[3] short anterior vaginal wall,[2] third degree retroversion of the uterus,[2] acute anteflexion of the uterus[2] or complete prolapse,[3] proper placement of the diaphragm usually will not be feasible. Safer than jelly applied to an improperly fitting diaphragm is jelly-alone inserted into the vagina. Inability to learn the diaphragm technic also necessitates jelly-alone.

From the patient's point of view: The highly fertile multiparous patient who considers her family complete will seek the extra protection of a diaphragm. Women motivated by a morbid fear of pregnancy will prefer to reduce the risk of conception by using both a mechanical device and a spermaticide. Conversely, if there is no urgent need to avoid conception,[4,5] or if there is an unwillingness to use the diaphragm, jelly-alone will be the patient's choice because of its simplicity. Practical considerations, such as crowded living conditions or inaccessible toilet facilities may necessitate jelly-alone.

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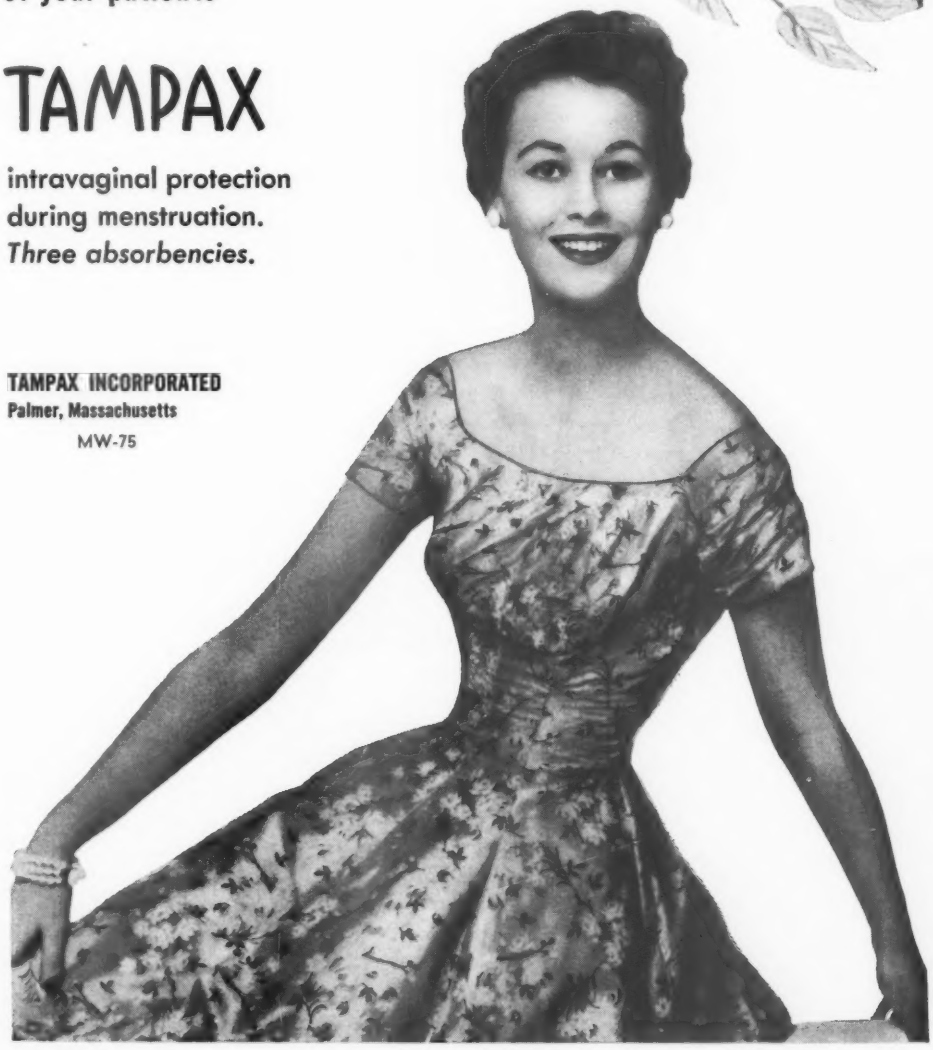

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Journal of the
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VOLUME 10 JULY 1955 NUMBER 7

World Health and World Peace

M. G. Candau, M.D.

THE GREAT EFFORTS being made by the so-called under-developed countries to bring prosperity to millions of people and to apply modern technology and science constitute one of the outstanding developments of our time. For the historians of the future, the significance of what appear to us to be the earth-shaking political and military events of our century will be dwarfed by the social and economic awakening of civilizations which had already contributed much to the philosophic and cultural heritage of modern man. By the same token, the history of international relations will be recorded not in terms of political and diplomatic treaties, but in terms of the steps taken by the more fortunate countries to help under-privileged nations to achieve higher standards of living and social progress in greater freedom.

Newspaper headlines continue to feature the stories of pitiful struggles between narrow and selfish interests, or between political and geographic concepts which have become entirely obsolete. But, in spite of this, more and more people begin to realize that the basic problems we are facing will be solved only if we accept mutual responsibility for the welfare of *all* people, not just locally, not just nationally, but embracing the whole human race.

We must free ourselves from the suicidal behaviour which has become our habit. In the last fifty years, man has devised forces which could lead us to a new world of plenty. Yet, during this period, we have spent most of our intelligence, skill, and energy in directing these same forces to the service of man's fight against man.

This may be our last chance to reverse this fatal trend. And the machinery of the United Nations, established after one of the most cruel wars in history, may well be the last tool offered to us for ensuring, through true international action, the prosperity, security, and peace of all.

It is to this principle of international co-operation that the World Health Organization owes its very existence. All the activities carried out by the World Health Organization are devoted to one fundamental aim: to assist countries to strengthen their health services, so that every human being may be able to reach the highest possible standard of health.

WHO proclaims the end of isolationism in the field of health, even the partial achievement of which has been shown by history to be one of the main factors in social and economic development. The individual and collective responsibility of all countries in safeguarding world health is summed up in WHO's constitution, which states that "unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger."

(Continued on following page)

Dr. Candau is Director-General of the World Health Organization.

While it has never so far obtained the funds necessary for even a minimum world-wide programme of health work, WHO has done much to diffuse among an increasing number of people the concept of universal responsibility in matters of health. Through the demonstration work that it has helped national authorities to carry out, it has shown conclusively what international assistance can contribute in dealing with health problems which for a long time seemed insoluble.

Perhaps the best way to define both the limitations and the potentialities of an organization such as WHO is to try to clear up some of the misunderstandings encountered in many places concerning the role it has to play in the field of health.

First of all, the final responsibility for the health and well-being of any peoples must rest with their own government. It is the government which must decide on the work to be done. WHO can only play its role when it is asked to help. For WHO is not a supra-national authority. It exists only to serve the people through their governments.

In fact, WHO can be considered as a clearinghouse through which knowledge obtained in medical science and public health is channeled to any country requesting it. It is a world co-operative to which the nations subscribe according to their financial capacity, and from which they draw assistance, as far as funds allow, according to their needs.

Like all true co-operatives, WHO is based on a system of give and take. All members contribute to the work of the Organization and all derive benefit from their association in various ways. Many of the activities carried out by WHO are indeed of direct benefit to all countries and can be carried out only with the full co-operation of all.

For example, radio messages, broadcast from Geneva daily, report the latest information on quarantinable disease occurring anywhere in the world. These warnings are received by ships at sea, planes in flight, port health authorities, and national health administrations in all countries. This is one of the many ways in which international co-operation safeguards the health of all peoples irrespective of national boundaries.

Through the WHO technical publications, the latest advances in medical knowledge and public health practice are made available to the world as a whole. The publication of an international pharmacopoeia and the standardization of biological products can be achieved only by the collective co-operation of all nations. Indeed, unless participation of all States is assured, we will not be able to ensure that medicines and drugs will have the same effective potency, no matter where they are produced or used. Only world action can guarantee world health.

A more basic criticism of the aims WHO has set itself is this: since our society suffers from a chronic shortage of food, is there any use in trying to keep people alive, if they are only going to die of starvation in the end?

To this counsel of despair there are several answers. The first is, of course, that it is not keeping people alive that matters, but keeping them healthy while they are alive. The sick who cannot work produce nothing, and must live from what others produce. The farmer with malaria, for example, may be unable to sow his crop or to reap it. Only by freeing him from his sickness and restoring him to his full strength, can we provide him with the means to fight his poverty.

Then it is obvious that people who die young diminish the economic potentialities of their country in either of two ways: first, through not reaching the productive years of life themselves, or else because their death reduces the number of fully productive people who have to support an aging population. For instance, in Brazil, more than half of the population is under twenty years of age. If one takes that age as a dividing line between dependents and producers, every producer in Brazil has at least one dependent. The effect on the productive power is obvious. Both high dependence rate and short life expectancy militate against economic progress. It has been estimated, in fact, that during the span of one generation in Brazil, it loses no less than 32 percent, almost one third of its potential total productive capacity, caused by premature death.

Another example of the strict relationship between better health and better living comes from Mysore State, in India, where the Rockefeller Foundation studied the cost of malaria to people in about twenty villages. Before spraying was started, almost one half of the family income was being spent to cover the cost of sickness. After spraying was completed, this expenditure was reduced to 5 percent, a saving in round figures of about 600 rupees per family per year. And the people had their health as well.

If we look now at Ceylon, we find that in the seven years since malaria control became effective, the government of that island has reclaimed and brought under irrigation more than 206 square miles of previously uninhabitable malarious jungle. As a result, many people who previously had no land are now working in 26 new colonization schemes.

In Northern Thailand, it was found that each malaria attack incapacitated its victim for more than seven and a half days. Within one year of DDT spraying, the productive power of the population had been increased by no fewer than 25,000 work weeks.

It is sometimes argued that because the world's population is rising at the rate of 40 million a year, or more than 100,000 every day, we shall eventually be unable to feed ourselves. The question is asked, what will we do in 50 years' time, when the 2,500 million people in the world today will have increased to 5,000 million?

A good answer to this argument was given by Prime Minister Nehru last year when speaking on the health problems of Southeast Asia. Mr. Nehru emphasized the theoretical nature of predictions concerning the state of the world 50 years from now and said that the first step towards solving the problem was to treat people not as blocks of figures or curves on a graph but as individuals who must be convinced of the cause to be furthered.

In its own field, this is precisely what WHO is doing. Through demonstration work, it is trying to convince people that ill health is not an inevitable visitation of fate. The very existence of hundreds of health projects carried out by governments today shows that this point of view is being accepted. Why should we retreat before the challenge of the food and population problem?

Today in North America, food production is 46 percent higher than it was before the war. In Latin America and Africa, and the Eastern Mediterranean, it is one-third higher. The fact that food production in Asia as a whole is 18 percent lower than it was 15 to 20 years ago stands before us as a challenge. What has been done in one part of the world can be achieved in another.

Such a challenge can be met only by people who are fit in body and mind. The prime task before WHO is to help governments to realize the powerful protective potential of positive health. In doing so, governments and WHO must decide jointly on the type of health projects which will give the greatest results and for which international assistance is the most indicated.

Improvement of health is, however, only one factor in the general advance of a country. As it goes along with its work, WHO realizes more and more that its efforts, and the national activities they stimulate, are of no avail, if they take place in a social, economic, and political vacuum.

To all of us engaged in the building of the new world, it must be obvious that the ideal of health expressed in WHO's constitution as "complete physical, mental, and social well-being" will be achieved only by simultaneous advances in all social and economic fields. The people freed from the slavery of disease must be able to find work. They must also be reasonably sure of finding markets for the produce of their labour, and finally, if they are to lead a productive and happy life, they and their children must also be given greater educational and cultural opportunities than the great majority of the world is enjoying today.

What does all this mean? For the UN and its specialized agencies, it points to the absolute necessity of combining, whenever possible, whatever assistance they can give to a country engaged in the process of general development. Indeed, if they are isolated, the contributions made by agencies such as UNESCO, ILO, FAO, the International Bank, and WHO will not amount to much. But, if these are given in harmonious association, and if, together with national endeavours, they are planned not for just now, or for ten or twenty years, but for two or three generations ahead, then these efforts will yield great and enduring results for prosperity and peace.

Onchocerciasis: A New Field of Activities

Mario Giaquinto, M.D., L.D.T.M.

ONCHOCERCA VOLVULUS, the "blinding filaria," is the worm causing the disease called onchocerciasis, which has recently been studied by the World Health Organization. This disease is not generally known outside its endemic areas, but represents, nevertheless, an important social and economic problem for large and, up to the present time, not completely defined parts of America and Africa.

The most characteristic clinical manifestation of this disease is the appearance, in different parts of the human body, of subcutaneous nodules (also called tumours) which contain the adult worms and which vary in size from a few millimetres to about 5 or 6 centimetres. These nodules generally are not disturbing, although in some cases they may be painful. But even if the nodules do not cause much trouble to the patients or may pass unnoticed by many of the most primitive inhabitants of the endemic areas, they are, nevertheless, the starting point of much more serious effects. These generally follow the appearance of the nodules and consist of skin lesions and, especially, characteristic eye lesions. They constitute the really serious manifestation of onchocerciasis and confer on this disease its importance as a public health problem.

The lesions are caused by the embryos of the *Onchocerca* worms, called microfilariae, which are produced by the female adult worms located in the nodules. The microfilariae invade the tissues of the skin and the eye through the lymphatic circulation: they do not appear in the bloodstream as do those of the other species of filarial worms. In the skin and the eyes, the lesions seem to be produced both by direct action, mechanical and toxic, of the microfilariae, and by allergic reactions of the patients. Discussions are still going on concerning the ability of onchocerciasis to produce elephantiasis.

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Ocular disturbances seem to occur late in the course of the disease and serious lesions are generally observed only five, six or more years after the appearance of the nodules. They are generally of insidious onset, so that patients are not alarmed while the disease progresses. "Onchocerciasis may attack all portions of the eye, with the exception of the lens." [1] The sight of untreated patients gradually deteriorates in the course of years, and blindness, or a loss of visual acuity sufficient to affect the working capacity of the patients, is reached in a high percentage of the affected persons.

The presence of the nodules of onchocerciasis was first observed by a German medical missionary,[2,3] and studied by Leuckart[4] in 1893, who described the worm, calling it *Filaria volvulus*. The disease was well known for many years in Africa, but it was only in 1916 that Robles,[5,6,7] after having noted the disease in Guatemala in 1915, pointed out the existence of the ocular lesions, showing that they were caused by the worm. This was later described by Brumpt[8] as a new species, morphologically almost identical to the African one; Brumpt separated it chiefly on account of the capacity of this species to produce the ocular lesions, hitherto unobserved in Africa, calling it *Onchocerca coecutiens*, the "blinding" filaria.

It is certainly strange that the discovery of the ocular lesions and blindness produced in Central America by *Onchocerca* was not followed, until about 23 years later, by realization of the existence of similar lesions among great numbers of patients affected by onchocerciasis in Africa. It was, in fact, only in 1939 that Hissette[9-12] gave an excellent description of ocular lesions due to onchocerciasis in the Belgian Congo. He showed that blindness and severe reduction of visual acuity affected the population of entire villages and considerable areas in that country.

Roughly, it can be said that the disease affects large areas of Central, East, and West Africa, while

in Central and South America, endemic areas are well known in Guatemala and Mexico, and others, whose limits are still unknown, have only recently been detected in Venezuela. Cases which may be autochthonous have been reported from Surinam, and one single case, which seems, however, to be autochthonous, has been described by Léon[13] in Ecuador.

In both continents, infections have been shown to be present in high percentages of the population; rates of infection reaching 50 percent and 70 percent have frequently been reported and rates ranging from 80 percent to 100 percent are not exceptional.

The disease may exist over wide areas, as in Central and West Africa, or may be comparatively localized, as seems to be the case in East Africa and Central and South America. There are great local differences between known rates of occurrence of ocular complications, especially between the degree of severity of lesions reported from various areas. In limited zones, surveys have shown that eye complications may affect 50 percent of the population in South America and 75 percent in Africa.

In some of the American endemic areas, it has been demonstrated that blindness may reach proportions varying from 0.45 percent to 3.3 percent of the total population, and exceptionally, even more; in 1933, the writer and Diaz[14,15,16] observed on a small coffee plantation in Guatemala, where practically all the inhabitants were carefully examined, that the percentage of blindness reached 15.6 percent. Even higher proportions have been reported in some African districts.

The disease is not passed directly from man to man, but is spread by a species of flies, belonging to the genus *Simulium*.

The *Simulium*, of which various species also exist in the United States, where they are commonly called "gnats," deposit their eggs in the vegetation or on the rocks and stones submerged in running water of streams and rivers; the females walk directly under the water, undisturbed by the strength of the current, and carry their supply of air between their closed wings; the eggs produce larvae which, although capable of movement, are generally attached to the same supports, and the following stage, the pupa, inside a kind of cocoon, also remains attached. The adults emerge from the water and are commonly found near water courses although they are capable of flying, actively, or aided by the wind, considerable distances.

Only the female of the genus *Simulium* bites to suck blood; when those of the vector species bite patients whose skin contains microfilariae of *Onchocerca*, the *Simulium* become infected by those

Examination of patient with onchocerciasis.

microfilariae, which are first introduced into the stomach. Later, they pass through the walls of the stomach, migrating to different parts of the body of the insect, chiefly in the muscles of the thorax. In those muscles, they undergo a series of transformations which enable them to develop into "infecting larvae," small worms which migrate from the insect through its proboscis, on occasion of another blood meal, penetrating into a new human host. Once again in the man, the worms, through an evolution the details of which are not yet completely known, develop into a new adult *Onchocerca*, originating a new subcutaneous nodule, thus starting the cycle again.

The role of these insects as vectors of onchocerciasis was first demonstrated in Africa by Blacklock[17,18,19] for the species *Simulium damnosum* Theobald, and later, for Central American species by Hoffman[20-27] in Mexico. He proved the infectivity of *S. callidum* D and K and found evolutionary forms of microfilariae also in the species *S. metallicum* Bellardi and *S. ochraceum* Walker, although expressing doubt about the capacity of the latter to act as vectors in nature. Strong and coworkers[28,29] proved, however, that the cycle of evolution of the parasite could be completed also in *S. callidum* and *S. ochraceum*. Finally, in 1936, the writer,[30] demonstrating the preference of *S. ochraceum* for human blood and comparing the geographical distribution of the disease and of the three above-mentioned *Simulium* species, concluded that *S. ochraceum* was to be considered the most important vector in Guatemala. This conclusion has since received universal acceptance also for the endemic areas of Mexico, and proved of considerable interest since control campaigns may be envisaged as aimed at controlling only the important species (species sanitation), thus reducing the cost.

Another species of *Simulium, neavei,* that was also proved capable of acting as a vector in Africa by Hissette, Strong[31] and McMahon,[32] for a long time baffled research workers investigating its biology to ascertain possible control measures. Although adults were common and attacking man severely, it was impossible to find a single larva in the water courses. Finally, McMahon[33] solved the puzzle after years of patient research, showing that the larvae of this species, instead of being attached to the submerged rocks or vegetation, are attached to a particular species of sweet water crab, which offers support and free transport.

By biting voraciously and generally painfully, normally early in the morning or at sundown, but also during the day, especially in the shade of forest or sub-forest vegetation, *Simulium* represent a great nuisance and are considered as pests. Apart from their capacity to transmit onchocerciasis, they are capable of forcing the population to avoid certain areas. It is therefore easy to imagine what effective vectors they may be in cases where 100 percent of the population harbour microfilariae in their skin and one person may be bitten often, by as many as 200 insects per hour!

Simulium and onchocerciasis, therefore, have greatly reduced the possibilities of exploitation of otherwise fertile and rich territories, and have obstructed or made more difficult the implementation of such projects as forest exploitation, dams and irrigation projects, and cultivation. At the same time, the development of certain economic activities, such as fishing, hunting, and especially coffee cultivation, by increasing the exposure of the population to the attack of the *Simulium,* have certainly contributed to the spread of the disease and to a higher incidence and severity in various areas.

For a long time, attempts to cure and control the disease were not very rewarding. Until a few years ago no drugs capable of affecting adult *Onchocerca* and their microfilariae in the human body, when employed orally or by injection, were recommended for general use. Treatment by surgical excision of the nodules offered good possibilities, but is too difficult to apply for mass treatment; attempts to inject different drugs into the nodules, by various workers, including the writer, even if more practical for mass treatment, were not constant in their results. Measures for the control of *Simulium,* especially because of limited knowledge of their biology and the lack of adequate techniques, had proved to be generally ineffective and too costly.

Growing consciousness of the importance of the disease as a public health problem, nevertheless, continued to stimulate research activities. Attempts were made to apply to the field of onchocerciasis discoveries of new insecticides as well as more effective drugs. Also there was increasing acceptance of the necessity for efforts carried out by so many workers of different nations, unfortunately in an uncoordinated manner, to be fortified by integration in an internationally co-ordinated programme.

Delegations of various interested states, including Belgium, Mexico, and Guatemala had already repeatedly pointed out the importance of the problem of onchocerciasis to the World Health Assembly; consequently, it was the privilege of the Fifth World Health Assembly to pass the resolution which started increased interest in onchocerciasis by the World Health Organization. The Organization had, however, through the Regional Office for the Americas, already assisted some anti-onchocerciasis activities in Guatemala.

Following that resolution of the Assembly, an Expert Committee on Onchocerciasis was convened in Mexico in November 1953. Thanks to the kind support of the Government of Mexico, the meeting was held at the Institute of Health and Tropical Diseases. A visit to the endemic area of onchocerciasis was carried out in the Tapachula district to observe local epidemiological conditions and to study the control measures applied by the Mexican public health authorities.

A considerable degree of agreement was reached by the experts on various debated problems. For the first time, standardized methods for carrying out epidemiological surveys, enabling comparison of results obtained in different countries or at different times, were proposed, and adequate techniques for these surveys, for treatment and for control measures, were recommended. The Committee considered that "efficient and practical methods to control onchocerciasis are already available." [1]

It was agreed that the systematic campaigns carried out in Guatemala and Mexico for the surgical excision of the nodules had greatly reduced the incidence of blindness among the patients, even if they had not been able to reduce, in the same measure, the incidence of the disease. The possibilities and the limitations of the new drugs, for both individual and mass treatment and for prophylaxis, both against adult worms and microfilariae, were well specified.

In the field of *Simulium* control, the successes obtained by Wanson[34,35] in Leopoldville, and Garnham and collaborators[36,37] in Kenya, in controlling these insects with different techniques, were adequately recognized. Suggestions for their use were embodied in a series of interesting statements.

This meeting largely confirmed existing hopes and represented an important step in the history of the fight against this disease. At the end of the meeting, the participating experts decided on the foundation of a permanent international society to maintain contact among all private interested research workers and to co-operate with WHO in future activities against this disease.

The society was founded effectively under the name of the International Association against Onchocerciasis, with an interim committee to present proposals for final organization and to start immediate activities.

As part of its programme of developing anti-onchocerciasis activities, WHO in 1954 called the first Conference on African Onchocerciasis.

The Conference was held in Leopoldville, where the Belgian government kindly acted as host, in October 1954. All governments administering territories possibly interested in onchocerciasis problems were invited to send representatives. A group of international experts were also invited, including one from the endemic areas of America, as well as representatives of inter-governmental and non-governmental associations interested in onchocerciasis..

The WHO invitations were eagerly accepted by many governments; each not only appointed a representative but also sent delegations. The latter included highly qualified specialists, with field experience in the study and control of the disease they were pursuing, often under very difficult conditions, in different and sometimes remote parts of Africa. UNICEF, always interested in problems possibly related to the health and well-being of children everywhere in the world, was also officially represented at the Conference.

In order to supply information required for the Conference, special surveys were made by Spain (Spanish Guinea) and Italy (Trust Territory of Somaliland). The surveys confirmed the absence of the disease, but showed the presence of the vectors. Statements on the non-existence of onchocerciasis problems in their territories were forwarded by the governments of Tanganyika, Swaziland, Bechuanaland, and Basutoland.

Discussions, which often reached a high technical level, permitted a wide circulation of the Report of the Expert Committee among particularly interested and responsible officials, as well as an exchange of information on local conditions of the disease, on experience and results of attempts at control, techniques and methods employed, difficulties met, needs, and projects.

Some of the most important results of the discussions can be summarized as follows:

1. Data for a map of local distribution of the disease in Africa were assembled, thus permitting a study of onchocerciasis on a continental basis.

2. The importance of the density of the microfilarial infection in producing the high percentage of blindness and other serious lesions was recognized; differences of opinion on the possibly non-onchocercal origin of some lesions of the posterior part of the eye were pointed out and discussed, thus contributing to an increased interest in a point hitherto scarcely investigated, and to the preparation of plans for new research.

3. Good prospects of control activities, both for mass treatment of patients and for vector control, pointed out in the report of the Expert Committee on Onchocerciasis, were entirely confirmed and new, even more hopeful data were added, resulting from field work which had followed the meeting of the Expert Committee. Thus, toxicity risks of various drugs were recognized to be less than generally believed, chiefly on the evidence of the work carried out in the French Territories, while new and extremely good results obtained by *Simulium* control (anti-larval) activities were reported by Kenya and Uganda.

As for the future, while the possibility of effective action was confirmed, the necessity was recognized of co-ordination of national programmes, especially for many endemic areas located along the frontiers of different territories. WHO was invited to take the initiative in such co-ordination, to assist in the organization of international surveying and training programmes, as well as in the carrying out of national projects. An appeal was addressed to UNICEF to extend its assistance to the field of onchocerciasis.

The Conference expressed the wish that a new meeting should be called for 1957, to review data on progress of planned activities to be carried out before that time.

In addition to the great interest taken by the governments represented in the future programme of onchocerciasis control, it was interesting to note the stimulating contributions to the discussions made by the non-governmental institutions, and the fact that they were thus able to establish contacts among themselves for the first time. This collaboration of private initiative against onchocerciasis in different countries represents an additional result of the Conference, the importance of which must not be underestimated.

The discussions of the first session of the WHO Expert Committee on Onchocerciasis and the First Conference on African Onchocerciasis have established that it is possible to succeed in controlling

the disease. Among the practical activities which WHO is starting in this field, the following may be mentioned: a WHO consultant is scheduled to visit Venezuela to assist in completing epidemiological research and planning of suitable control activities; studies are under way for assistance to be given a first pilot project in one of the most affected areas of Central Africa. Moreover, WHO will endeavour to co-ordinate and assist the efforts at control which are being made both nationally and internationally.

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The World Health Organization and Tuberculosis in India

E. J. T. McWeeney, M.D.

THE PROBLEM OF TUBERCULOSIS in India may be stated in these terms: about five hundred thousand people, most of them in early adult life when the value of human life is at its maximum, die annually in India from tuberculosis. In the West, the annual death rate from tuberculosis of the respiratory system was:[1] in Denmark, 1952, about 10 per 100,000 population; in the United States, 1952, around 12; in England and Wales, 1952, it was about 21. For India, on the other hand it may be as high as 300 per 100,000 population, and similar rates are to be found in most other Asian countries.

This is an appalling figure and the mortality rate does not tell the whole story. It is probable that there are at this moment in India some two and a half million open infective cases of tuberculosis. Against this estimate, the total number of beds available for isolation and treatment is not more than about 16,500. There are about 165 tuberculosis clinics as compared with an estimated need of 4,000. There are only a few hundred doctors fully trained in tuberculosis as a specialty, and even fewer trained nurses and tuberculosis health visitors.

Any successful attack on the tuberculosis problem must be made on a number of fronts. Bad housing and malnutrition must be remedied. The people must be taught sound principles of hygiene. A large number of beds for isolation and treatment must be provided, as well as an adequate number of clinics, equipped for diagnosis and control of tuberculosis.

Following the report of the famous Bhore Committee,[2] before World War II the then Government of India considered the organisation of a comprehensive and integrated tuberculosis service which would have included many of these measures. India has had only a few years of self-government, during which time her energies have had to be spent largely on dealing with the urgent refugee problem and in maintaining a large and costly defense force. Therefore, funds for a full-scale attack on tuberculosis had been lacking. Indeed, it is doubtful if within the near future such an attack will be possible.

Realizing that a similar situation exists in other countries of the Southeast Asia Region, the World Health Organization's Expert Committee on Tuberculosis considered the problem carefully and decided to recommend to governments the formation of demonstration and training centres at strategic points in various countries. The committee that made this recommendation included men who had made a close study of conditions in these Asian countries, such as Dr. P. V. Benjamin, tuberculosis advisor to the Government of India, and Dr. J. B. McDougall, then chief of the Tuberculosis Section, WHO Headquarters.

The purposes of the demonstration and training centres would be:

1. To ascertain the real amount of tuberculosis infection in the areas where the centres would be located; to find out in which economic groups the infection is especially prevalent, and which age groups are especially affected. This has been and is being carried out by means of surveys employing tuberculin testing, fluorography and, in some cases, bacteriological proof of infectivity.

2. The centres would be designed to show doctors, nurses, technicians, and government officials (who would be concerned in the setting up of health schemes) the most recent methods of tuberculosis control by accurate diagnosis, domiciliary and institutional isolation, and preventive inoculation. This control is based on breaking the chain of person to person infection.

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3. The centres aim to train the greatest possible number of doctors, nurses, and technicians in various aspects of the specialty of tuberculosis. In addition, the centres are designed to serve as model tuberculosis services for the people in their areas.

When possible, use would be made of existing tuberculosis clinics and governments would be asked to adapt or extend these clinics suitably. A team of international experts in the various aspects of tuberculosis control — clinicians, public health nurses, epidemiologists, bacteriologists, roentgen technicians, and laboratory technicians—would be stationed at each centre and would work with the international team; the local government would provide a team of national counterparts. When adequately trained specialists were available, they could be assigned to take their places with the international team. Radiologic and laboratory equipment of the most modern type would be furnished.

Let us see how this scheme has developed in India because this is a good example of how the problem has been handled throughout Southeast Asia. Three centres have already been set up: one at Delhi, one at Trivandrum, and one at Patna.

At the Delhi centre, use has been made of the excellent pre-existing clinic premises to which considerable additions have been made by the efforts of the All India Tuberculosis Association and the government. The former medical director of the clinic remained as medical director of demonstration and training centre. To assist him, he had the services of international personnel, including an epidemiologist, a bacteriologist, a public health nurse, a roentgen ray technician, and a laboratory technician. National counterparts were provided by the government to work with the international personnel. This meant that each international member had a local doctor, nurse or technician working with him, who was trained to take over the various posts on the withdrawal of international assistance. There were trainees also in other categories.

At Trivandrum, there was no pre-existing clinic on which to base a demonstration and training centre. It had to be started in premises adapted from those formerly used as the state mint. There was a WHO senior adviser who had as a counterpart a national assistant clinic director. The international team consisted of a public health nurse and a laboratory technician, supplemented by periodic visits of an epidemiologist, a bacteriologist and a roentgen ray technician. The international assistance to the Trivandrum tuberculosis centre ceased early in 1953, and the national personnel took over complete charge. Evaluation of the results of WHO assistance is being made.

The State of Bihar built up a fine clinic at Patna. The key members of the Indian counterpart team received preliminary training at the Delhi centre. In 1953, charge of the Patna centre was given to the national personnel. Further assistance may be given by WHO in the setting up of other centres in which the experience gained will be utilized fully.

It should be emphasized that the endeavour in these demonstration and training centres has been to put the accent on the prevention and control of tuberculosis rather than on its treatment. In this regard, the attempt has not been as successful as had been hoped. Up to the present, medical teaching and the medical climate generally has featured clinical rather than preventive work, and this applies to the Asian countries generally.

In view of the shortage of institutional beds, special emphasis has been laid on the teaching of domiciliary isolation. It is known that domiciliary isolation in a fully effective sense is impossible in a large proportion of Indian houses in poorer quarters, but some measure of it can often be secured, and patients and their families can be given useful lessons in the avoidance of infection.

Another project in which WHO is assisting the Indian government is in the formation of a Chest Surgery Unit where teams of surgeons, theatre sisters, anaesthetists, and physiotherapists may be trained in the modern development of chest surgery which often renders patients non-infective, eliminates the disease itself in some cases, or permits the return of the patients to a modified life of useful work. The Thoracic Surgery Unit began work at the end of April 1954 in the Silver Jubilee Tuberculosis Hospital at Delhi.

One Southeast Asia government has been helped and it is hoped that another soon will be helped by WHO's providing expert country advisers on tuberculosis at health directorate level. BCG preventive vaccination has already been mentioned. Children and young adults are first tested with tuberculin to ascertain whether they have or have not been infected with the tubercle bacillus. If they have been infected, it is considered that some measure of immunity against tuberculosis has been effected. If they have not been infected, an artificial immunity is created by means of an injection of a minute quantity of vaccine.

Efforts of the Government of India to operate mass vaccination campaigns with BCG have been assisted since 1949 by the International Tuberculosis Campaign (a joint enterprise of the Scandinavian

Red Cross Societies and WHO) and since July 1951 by WHO and UNICEF.

Wherever possible, BCG vaccination is integrated with the work of the tuberculosis demonstration and training centre, but its main employment has been in mass campaigns directed at reaching millions of people in the various Indian states. The vaccine used is produced in the Guindy BCG Vaccine Laboratory in Madras. This laboratory supplies vaccine to other Asian countries also.

At present, every month one and a half to two million persons are tuberculin tested in India, and those who need it are being given BCG vaccination. There are 119 teams of 6 technicians each. One doctor supervises four teams. This is a very high number, but it does not mean that WHO's goal in India has been reached. If all the young persons who need vaccination are to be reached within a period of five years, it will be necessary to step up the output of the Indian BCG campaign considerably. This may seem unattainable, but the results obtained in the past indicate that there is reason for optimism. What can be reached by public help and interstate co-operation has been clearly shown by the BCG drive held in the spring of 1953 in Delhi with the assistance of teams from the neighbouring states of Uttar Pradesh and Punjab. In the city, 750,000 persons were tuberculin-tested within a period of four weeks. This proves that mass vaccination can be organized on a greater scale than it is done at present. And this proof was confirmed by a similar and more spectacular drive at Coimbatore in 1955. The BCG campaigns in the Asian countries are the greatest mass attacks ever made on a communicable disease problem. UNICEF and WHO have helped with supplies, planning, and technical advice; but the major share of the credit must go to the governments and the people of the various countries.

This fight against tuberculosis cannot be won by WHO or by national governments. It must ultimately be fought and won by the people themselves, acting on the knowledge that tuberculosis is a preventable disease and taking steps to prevent it. Here is a great challenge which the health services of Southeast Asia must face if tuberculosis is to be prevented, controlled, and arrested.

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An Anti-Leprosy Campaign in Burma

P. H. Lampé, M.D.

THROUGHOUT THE CENTURIES, leprosy has been feared and hated as the most disfiguring of man's affilictions. The leper has been cast out from the society of his fellow men. Now, medical science has not only proved that leprosy is no more contagious than tuberculosis, but also has discovered that drugs of the sulphone group can reduce and check the contagiousness of leprosy cases and even cure certain of its manifestations.

Today, doctors recommend segregation only for the comparatively few patients who are suffering from the disease in its more contagious stages. Popular opinion gradually is accepting leprosy victims as less dangerous to society than sufferers from many other diseases.

With the new knowledge, many countries have overhauled their leprosy treatment services in recent years. Along with other governments, the Government of Burma asked for advice and help from the World Health Organization. WHO assistance in the national anti-leprosy activities of Burma began in 1951 when a WHO consultant spent three months there. The consultant's preliminary survey confirmed the fact that leprosy was a huge problem in the country and particularly in Central Burma and the Shan States. In 1952, the Burma government decided to launch a national anti-leprosy campaign, and the World Health Organization assigned this writer to advise and assist in planning and organizing the work, and to integrate the campaign into the national health programme.

The aim of a modern anti-leprosy campaign is to bring the sulphone treatment within the reach of as many sufferers as possible. This reduces the reservoir of infection and arrests the spread of the disease. To achieve this, it is necessary that the authorities and the public be educated to the fact that no stigma is attached to leprosy. Futhermore, the sufferers, their families, and their friends must be convinced of the need for treatment, and must have confidence in it.

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In charge of the national anti-leprosy programme is Dr. U Tha Saing, assistant director, National Health Services. Dr. Saing insists that the staff of all clinics and treatment centres should be trained with these aims in view. One of the most encouraging facts about the Burma campaign is the ease with which the propaganda drive conducted by Dr. Saing and his fellow workers paved the way for successful progress.

In Burma, as in other countries where leprosy prevails, the medical profession was somewhat slow in recognizing the need for rationalization of its attitude towards the disease. Leprosy was generally considered progressive, terminating in bad disfigurements and death; but the alarming picture of progressive leprosy is exceptional compared with the frequency of mild forms.

Owing to this misconception and the fatalistic view that nothing worthwhile could be done to arrest the advance of leprosy, the disease was looked on as a disease apart, not on the same footing with other contagious diseases in the domain of medical responsibility. Thus, notwithstanding the fast development of medical services, the care of leprosy patients remained the almost exclusive concern of mission and charitable institutions, following the mediaeval concept of the care of the sick.

To strengthen the idea that leprosy is just an ordinary disease for which people naturally seek treatment, the site chosen for the main ambulant treatment centre in Rangoon was a vacant school opposite the General Hospital and next to the outpatients' clinic for skin and venereal diseases. The clinic now is known as "Special Skin Clinic" in both English and the vernacular, and is one of the most popular clinics in Rangoon, with a fast growing number of patients.

In addition, two auxiliary clinics are operated in the outskirts of Rangoon; and the old treatment facilities used for advanced cases in a clinic attached to the Leprosy Asylum in Kemmendine, a suburb of Rangoon, were brought into line, with 700 patients attending regularly. Altogether, over 3,500 cases are enrolled in Rangoon alone, 2,400 of whom attend for regular treatment without fail.

Although ambulant treatment is preferable for the majority of cases, sanatorium accommodation is

still necessary for specially selected patients. A new State Sanatorium with accommodation for 300 patients was built on a 200 acre site at Htaukkyan, 20 miles from Rangoon. In October 1953, the official opening took place. The sanatorium is full and further accommodations for 200 patients are being built. The main buildings face the busy highroad between Rangoon and Prome and are called State Sanatorium for Special Skin Disease.

Leprosy in the household is considered a disgrace to be kept dark. Therefore, early signs of leprosy have usually been overlooked or ignored. For the same reason, parents were reluctant to send a child with signs of early leprosy to the "leper" clinic of the Leprosy Asylum in Kemmendine. This explains why hundreds of children with early leprosy were found among the schoolchildren in Rangoon, none of them ever treated except for a few with a history of private treatment discontinued for lack of funds.

If there is a badly disfigured patient in the household, as a rule no restrictions are imposed upon the leprous housemate; nor are precautions taken by the healthy housemates, accustomed as they are to the daily presence of the unfortunate mate.

Occasionally the victim leaves the household, either to live alone or to join the bands of homeless lepers living on the streets. Typical of many is Maung Tun, a former government official, who could no longer endure being a disgrace and a helpless burden to his wife and children; he left home and lived on the streets until found by the police. Often a disfigured sufferer is deserted and left alone, or turned out from the home.

Another case, one of many, is of Ma Khin Nyunt, a girl aged 15 years, turned out by her stepmother because the neighbors learned of her disease. She carried her sleeping mat and bundle of belongings to the clinic, crying for a place to sleep. Now, a pupil nurse in the hospital ward of the new State Sanatorium for Special Skin Disease, Ma Khin Nyunt is one of the most cheerful young ladies in the sanatorium community.

As in most cities of Southeast Asia, Rangoon has always had numerous leprous beggars. Desperate or indifferent, banded together, they constitute a kind of separate society, often difficult to approach. With the opening of the State Sanatorium, it was possible to induce 100 leprous beggars in Rangoon to enter the sanatorium voluntarily; another 30, not yet willing to give up begging, gambling, and roving about, are isolated by force in a special ward of the Kemmendine Asylum. Many more lepers are still begging and going without treament.

Public health nurse in Burma.

It was different in Mandalay, the second biggest city in Burma. There, a band of over 200 leprous beggars, plying their trade on the markets and crowding public festivals, were easily persuaded to accept treatment and care in a new shelter for destitute cases established near the town. The shelter now accommodates 350 patients.

In Burma, leprosy is mainly a rural problem. Dr. Saing's aim was to train non-medical personnel to implement the mass treatment campaign throughout the country. The first objective was therefore the training of full-time leprosy inspectors to work in the highly infected rural districts. The first group of 16 trainees, recruited from the ranks of public health inspectors with long experience in rural areas, followed a six month course in all matters pertaining to leprosy control such as propaganda, case finding, early diagnosis, and treatment. They left for the districts in early 1953.

From that time, events moved quickly, and little more than a year later 9,000 cases were receiving outdoor treatment in the rural areas. Under the auspices of the District Leprosy Relief Associations, 13 shelters for destitute cases had been established and were dealing with a further 800 cases. Another 2,100 advanced cases were cared for in seven different state and mission institutions. After adding treatment in Rangoon, the number of leprosy patients under control totalled 14,000, as compared with 2,500 at the start of the campaign. At present, the number is 21,600, including 3,330 in institutions.

The second phase of the campaign is now under way. A further group of 12 leprosy inspectors have been trained and have left for their duty stations. The leprosy inspectors stand in the frontline of the campaign, but 200 health assistants as village health workers, posted in rural parts of the country

(where no qualified doctor ever comes), are familiar with the treatment of minor ailments, the application of routine preventive measures in disease control, and the diagnosis and treatment of leprosy.

With the full implementation of the second phase, the area served will cover the most densely populated parts of the country where it is calculated that 14,000,000 of the 17,500,000 population reside. There may be 100,000 out of the 14,000,000 or 0.6 percent afflicted with manifest leprosy. This includes Rangoon's 6,000 cases (6,000 out of 800,000 or 0.75 percent).

The goal is proper sulphone treatment of about 30,000 cases, for an average of at least two years. New cases are taken, as treated cases, fall off on account of cure, failure to attend, or death. This goal can be reached, and in the long run, it is believed it will thus be possible effectively to bring down the prevalence of leprosy.

The initial success of the campaign is due largely to the enlightened leadership of Dr. Saing, but also in no small degree to the newly trained leprosy inspectors who have been able to inspire the trust of the rural population and give them confidence in the treatment provided.

By now this trust is spreading from those already under treatment to those not yet acquainted with the existing possibilities; there is a sort of secret bond between the victims of leprosy. Moreover, as the multitude of victims' families, relatives, and friends become more and more familiar with the great benefit of treating early symptoms, it becomes easier to find and cure early cases.

At all stages of the campaign, the public is exhorted to take a rational view of leprosy, to assist patients after discharge from leprosy institutions, and to help the dependents of patients who are hospitalized or unemployed on account of the disease. Of utmost importance is the interest in the rehabilitation of leprosy patients on the part of the Ministry of Relief, Resettlement, and Social Welfare.

Home visiting is another essential part of the campaign: to teach the elementary principles of hygiene in patients' homes, to encourage regular attendance at treatment clinics, and also to track down early cases. For example, in one district, out of 163 family members examined during visits to patients' homes, no fewer than 40 showed signs of early leprosy and could be given proper treatment.

The reaction of the people to the campaign has been most encouraging. In the rural areas, government officials and influential citizens joined the newly formed leprosy relief associations, and both in Rangoon and in the districts, the facilities for outdoor treatment met with an eager response. People with mild or early symptoms, who do not consider themselves leprosy patients in the ordinary sense, particularly appreciate the opportunity for treatment in places entirely disassociated from leprosy asylums or leper colonies.

Today, better understanding of leprosy and easy access to treatment means a great relief to thousands of families in all walks of life in Burma. There is reason to believe that the foundations of the present anti-leprosy campaign have been well laid and that in the years to come Burma will be able to conquer once and for all this age-old enemy of her people.

Auxiliary Health Workers in the Eastern Mediterranean Region

J. D. Cottrell, D.P.H.

In an address before the American Public Health Association in 1953, the Director of the WHO Eastern Mediterranean Region, Dr. A. T. Shousha,[1] stated that in a representative country of the region "there was a population of 4,611,000 in 1945 and only 569 physicians: of these 308 were located in the capital . . ." He went on to say that "In the Middle East, there is a basic and urgent need not only to train many more doctors, nurses, and public health officers, but also to develop a medical and health corps dedicated to rural services." It is the object of this article to tell something of the training of these workers in the past and of the plans for the future.

The Problem

In the country mentioned, it will be seen that the ratio of doctors to population is about 1 to 8,000 and in rural areas 1 to 16,000. Yet that country is relatively well supplied with doctors. There are countries where the ratio is 1 to 60,000 and there are others which do not yet have a single doctor of their own, the entire medical profession being represented by a handful of foreigners; some countries with populations up to five million have no medical schools.

Nor is the nursing situation any better. In this whole region of some 170 million people, there are perhaps not more than five or six schools of nursing which would be regarded as adequate by modern standards. The training of other types of professional health staff is similar. Faced with this grave manpower emergency, many countries of the region have resorted to training large numbers of auxiliary health workers as an emergency solution until adequate professional staff is available.

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The Auxiliary Health Worker

The definition of the Administrative Committee on Co-Ordination of the United Nations and Specialized Agencies[2] of the term "auxiliary worker" is understood "to designate a paid worker in a particular technical field . . . who assists and is supervised by a professional worker."

A study of the experiments in the use and training of auxiliary workers by states in this region reveals a number of general principles which are emphasized by four important words in the definition. These are principles, not hard and fast rules; they seem to have led to success, but they have been set aside from time to time in individual countries to meet special circumstances.

In the first instance, the auxiliary is a paid worker. Such persons have less than professional knowledge; they need supervision, they are trained, almost by definition, to serve mainly in rural areas, and these and other requirements can hardly be met unless they become salaried members of a state or local government service. On the other hand, this imposes an obligation on the national authorities to provide attractive terms of service providing a decent livelihood, prospects of promotion to minor supervisory grades, and a reasonable pension. There is ample evidence to show that where these conditions are carried out, workers give a lifetime of loyal and efficient service.

Next, an auxiliary worker is one who works in a particular technical field. He is an expert in a few things and he has been described as a "specialist in miniature." There is, in fact, almost no limit to the number of types of auxiliary workers which can be utilized, ranging from auxiliaries with comparatively long and broad training who substitute for doctors to simple vaccinators and technicians trained to do blood counts or look for malaria parasites.

But the principle of restricted training remains. The whole purpose of training auxiliary workers is to solve an emergency manpower situation by producing a maximum number of adequately trained persons in the minimum time. This demands closest

co-operation between the schools and the employing public health administrations, between the producer and the consumer. The latter must conduct a rigorous job analysis and produce a careful job description. The former must teach to this job description and avoid strictly all extraneous matter. The training and use of auxiliaries are dictated by local needs and great elasticity is needed in drawing up a curriculum. The curriculum for a given class of trainee must vary not only from country to country but also may vary even within a country to suit local conditions.

Yet it is essential to remember that of all health workers, the auxiliary is the one closest to the people and most often in their homes and therefore simple training in social knowledge (science is too formidable a word here) should be shared in common by almost all types of auxiliary workers. The Administrative Committee on Co-Ordination[2] agreed "whatever technical training in specialized fields may be required for these groups of workers, it is desirable that certain common social objectives and techniques for developing self-help and co-operation in the community should be part of their training."

Thirdly, an auxiliary worker is one who assists a professional worker. In the eyes of the uneducated, the distinction between an auxiliary doctor and a full professional doctor, or between an auxiliary nurse and her professional counterpart is too fine to be drawn; yet the difference in knowledge and skills is in fact considerable. Therefore, it is essential that at all times and from the beginning of training to the termination of working life, a clear distinction be drawn between the auxiliary and the professional worker. In certain countries where this distinction has become blurred and where auxiliaries are permitted to work outside government service, they have attempted work above their capabilities or tended to swell the ranks of the quacks. In addition, there has been a drift away from the rural areas to the more financially profitable towns. Other countries have shown that these dangers can be avoided by appropriate administrative action.

Finally, an auxiliary worker is supervised by a professional worker. This question of supervision is really the crux of the matter and is implicit in much that has been said before. And yet in this region, it is one of the most difficult conditions of employment because of the same manpower shortage which has dictated the employment of auxiliary workers. The answer lies in careful planning and in mobilization of the supervisory staff. When planning a service containing auxiliary workers, arrangements must at the same time be made for supervision; and to enable future expansion, whenever an administration plans to train auxiliary workers, it must ensure arrangements to train supervisors also. At first, in remote rural areas, supervision may occur at long intervals, but the essential is that there be supervision and that it be regular. As the service develops, experience in some countries has shown that the best auxiliary workers can be recalled, given additional training, and used as minor supervisors. Finally, and this is a point not infrequently overlooked by countries, adequate and reliable means of transportation must constantly be available to supervisory staff. In this way, they can cover long distances and the needs of large numbers of auxiliary staff.

Types of Auxiliary Workers

Of the many types of auxiliary workers which have been trained in different parts of the world, countries in the Eastern Mediterranean Region have mainly had experience in training. 1) auxiliaries substituting for doctors (registered doctors); 2) auxiliaries substituting for nurses and midwives; and 3) auxiliaries substituting for sanitarians.

It is proposed to discuss very briefly the above types of auxiliary workers.

Auxiliary Doctors. The use of auxiliary doctors has been best developed in Iran, Pakistan, and Sudan. In Iran and Pakistan, the tendency has been to concentrate on medical care and to train what might rather be termed second grade doctors, and to some extent they have been allowed private practice. No particular emphasis has been placed on training in public health and preventive methods, but recent reports from Iran indicate that these workers employed at health centres in rural areas appreciate the importance of public health methods and respond readily to additional training.

In Sudan, a simpler type of auxiliary has been developed, the medical assistant. Training commenced as long ago as 1919 on a more or less apprenticeship basis, but has been formalized since 1946. Until recently, candidates were selected from among men who had already received training as dressers or nurses and given an additional 18 months' training in medical care and public health. More recently, another school has been developed giving a three year course of training to boys without initial experience. At the present time, over 400 of these medical assistants are employed, mainly staffing dispensaries in rural and semi-rural areas. Experience has shown that such auxiliaries, given appropriate terms of employment, are loyal and efficient throughout their working life, taking pride in their corps and their service.

In co-operation with the USFOA, a school for similar medical assistants is being developed at Gondar in Ethiopia. In this school, greater emphasis is being placed on preventive medicine and public health training. When fully established, the school should have an annual output of 30; the trainees are intended to staff health services in rural areas and to provide, within the limits of their training, integrated preventive curative services.

Auxiliary Nurses. Auxiliary nurses have been trained for different functions, but in general they are divided into two sub-groups: auxiliary hospital nurses and auxiliary public health nurses.

As in the West, the auxiliary hospital nurse is being trained in a number of countries in the EMR. Their function is essentially to help the professional hospital nurse, but in many cases they have to perform without adequate supervision, owing to the great shortage of trained hospital nurses. However, they normally work under close supervision of the fully professional worker, and are subjected to a continuous course of in-service training. Consequently, it is considered that a useful hospital auxiliary nurse can be trained in, say, six months. Training this type of worker too long is not only unnecessary but may also create discontent if the educational background and period of training approximate too closely those of the full professional worker. In appropriate circumstances, arrangements are made for the best of these workers to complete a full professional course of training.

The professional public health nurse requires a minimum of 4 years' training and should have obtained matriculation or equivalent, that is to say, 12 years' schooling, before commencing training. It will be years if not generations before an adequate number of professional public health nurses (health visitors) are available in most countries in the Eastern Mediterranean Region.

Training of auxiliary public health nurses has been developed in Egypt and Pakistan for some years, and with the aid of WHO and USFOA, training courses have been instituted in other countries of the region including Iran, Iraq, Libya, Ethiopia, and Syria. They may or may not have additional training in midwifery and are intended primarily for semiurban and rural health centres. Rural auxiliary nurses often have to work with much less supervision or assistance than hospital auxiliaries, and consequently need a longer period of training. Considerable experience within the region and elsewhere indicates that training should last at least 12 and preferably 18 months. Six month courses have been tried from time to time and finally rejected.

Public health nurse with trainees visiting home.

Training covers public health nursing very thoroughly and trainees receive some instruction in health care and nursing the sick, especially children. They are given a broad knowledge of environmental sanitation with special stress on personal hygiene, the control of communicable diseases in the area in which they work, a good knowledge of elementary nutrition, especially in relation to local foods, and a thorough knowledge of maternal and child health care at a nursing level. It should be emphasized that since workers of this type are constantly in the homes of the people, they must receive careful training in health education methods to the extent of their capacities.

A rather similar type of worker but with additional midwifery training at a higher level is being graduated from schools developed in Pakistan with the assistance of WHO and UNICEF. The Ministry of Health has been assisted in establishing four schools for this type of worker, and the course lasts 27 months. A special point is made of training the girls to teach the indigenous midwives in the area where they will work.

Auxiliary Midwives. The question has been raised as to whether it is necessary or wise to train midwives in this region. It has been stated that in these countries, the act of parturition is relatively simple and complications are infrequent, and that consequently it is unnecessary to promote the use of trained workers in this field. The same critics state that the danger to the coming generation is not

during birth but during the first two or three years of life, especially during the first month and at the weaning period.

However, in most countries in the region, women are accustomed to having some form of midwife assisting at birth. Sometimes it is a relative or neighbour, but more often it is an untrained, though not unexperienced, woman of the village. In many countries, these midwives exercise their profession as a hereditary right, obtaining their knowledge from their mothers. The profession is regarded as an honourable one and such women often have a relatively high status in the community. In fact there exists a felt need for some type of midwife and it is considered that WHO should assist in filling it.

However, attempts are being made to train a type of auxiliary worker who is something more than just a midwife. It is essential that whatever training the community midwife receives, it be directed from the outset toward public health and preventive practice. It is suggested she should be able to conduct simple ante-natal examinations; have sufficient knowledge to know when complications are developing either before or during birth, so that she can call in more qualified assistance; and finally provide simple advice and care to the family during the child's growing years. In other words, the ideal auxiliary worker of this type should be trained to provide simple care at the village level for the mother and child before and during birth and up to the school entry age.

In Sudan, a most valuable system of training has been developed for the semi-literate or completely illiterate village midwives. This training has long since passed the experimental stage and indeed was first commenced in 1920, though it was placed on a more formal basis in 1924 when girls from the provinces were admitted. Now there are some six schools giving an 8 month course for this type of midwife. After successful completion of the course, each woman is provided by the government with a simple midwifery kit, and most return to their villages, where they are licenced to practice midwifery, receiving a fee from the families served. This is a departure from the general rule enunciated earlier in this paper, but it should be noted these midwives are kept under strict supervision by the district health authorities, are recalled for refresher courses, and in extreme cases of incompetence may even lose their licences. All reports indicate that they give excellent service in accordance with their abilities.

Auxiliary Sanitarians. In Eastern Mediterranean Region countries, there exists a need not only for sanitary engineers and fully trained sanitary inspectors, but also for auxiliary sanitary inspectors. In countries where health services are at a very early stage of development, this may well be one of the first types of auxiliaries to be trained.

The WHO Regional Office has recently arranged for the Egyptian government to conduct a one year course, in Arabic, for auxiliary sanitary inspectors from nearby countries where such training is not yet given. These auxiliary workers receive a thorough practical training, within limits, in all aspects of environmental sanitation, appropriate to the type of community in which they will later serve.

Experiments in training this type of worker continue. The period cannot be considered as yet fixed, but probably nothing less than six months is advisable. Furthermore, in addition to the practical work done during his course, such a sanitary worker should have additional experience under close supervision before working on his own.

On a somewhat higher level, a number of countries including Cyprus, Sudan, and Pakistan are training sanitary inspectors according to the syllabus of the Royal Sanitary Institute in London.

Dental Auxiliaries. Auxiliary dentists have not been produced in the region, but dental nurses of the type trained in New Zealand[3] for work with school children are training in nearby countries. They are prepared to carry out simple preventive treatment including oral prophylaxis, the topical application of sodium fluoride, dental hygiene education, and so forth, as well as simple remedial treatment including filling of deciduous and permanent teeth and extractions under local anaesthesia. It is forseen that assistance might be given to countries in this region to establish courses of training for such dental workers.

Utilization

In the second report of the WHO Expert Committee on Public Health Administration,[4] the concept of rural health units is very fully developed. It is in these health units that auxiliary workers can be employed most fruitfully, working together as a team, each strengthening the other. The staffing of such units has been, and for some time to come must be, entrusted to auxiliary health workers working under distant supervision.

At this stage, it is necessary to say a word about providing people with an integrated health service. The report quoted defines an integrated health service as "the service necessary for the health protec-

tion of a given area" and includes medical care in accordance with the needs of the area as one of the functions of a rural health unit.

Similarly the report of the technical discussions held at the Fifth World Health Assembly states: "Experience had shown that attempts to minimize curative functions might fail. Perhaps it would be best to state that preventive and curative medicine should go hand in hand, emphasis being put on one or the other according to local needs." [5] In western communities, it can be taken as axiomatic that the focus for the provision of an integrated health service is the family doctor. When there is work to be done in the public health field for which he lacks either the time or the requisite technical skills, he is nevertheless drawn into the team, and generally those who need medical care are referred to him.

At the outset, it must be realized that this is largely inapplicable in the countries of this region, certainly in rural areas, for the compelling reason that there are no family doctors in the villages in most of the countries concerned. It follows therefore that the health unit must replace the family doctor of western countries, and must provide their populations with an integrated health service.

A somewhat paradoxical situation follows. In training professional health workers today, the need is to strengthen them in public health. Conversely, in training auxiliary health workers, it is necessary to stress that they must all receive some training in medical care. Even the vaccinator and the sanitarian should know first aid and perhaps simple treatment of a prevalent disease like malaria. Nor is this just expedient, to obtain the good will of the people, but rather it is good medicine and good health practice. Where workers are few, it is essential that they provide simple health care as well as preventive services. This is more and more acknowledged in the countries of the region; and where formerly a dispensary and a maternal and child health clinic (both presided over by auxiliary workers) might exist separately in a village, now they are being combined in one health centre or unit, and the workers are being trained accordingly.

Administrative Considerations

The use of trained auxiliary workers has given good results in many countries. Experience has shown that careful planning is necessary before establishing a service and commencing training. At a recent conference in New Delhi of staff from WHO and USFOA working in the Middle and Far East, it was suggested that countries should establish an interdepartmental advisory committee

Daily cleanliness inspection in Indian school.

on medical manpower. Such a committee would contain representatives of the ministries of health and education. It would survey the field and make recommendations about facilities for training, including availability of teaching staff; the availability of recruits and their potential educational standard; the numbers to be trained, considering that budget likely to be available for future employment; and so forth. This committee could also co-ordinate training with the job analyses drawn up by the public health administrators. Finally, it could advise the government regarding appropriate terms of service.

Where careful planning of this kind has been omitted, attempts to train and use auxiliary health workers have often failed. Where it has been carried out, the success achieved has been striking. A reasonably adequate health service for rural areas at low cost can be built up in the course of one or two decades pending the time when a full teaching staff is available.

It is appropriate to close with a quotation from the report of the WHO Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel.[6] "It is still imperative that use be made of semi-trained workers and these . . . when properly supervised may make an invaluable contribution to public health . . . In considering the training of auxiliary workers, however, the committee was impressed by one obvious need in any community: that facilities for the instruction of

trained staff, particularly teachers and administrators, should be established before approaching the question of auxiliary workers. If this were not done, it would be impossible to retain reasonable standards of competence or to ensure proper supervision of auxiliary staff."

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World Health Organization Publications

A. Manuila, M.D.

Publications by WHO are similar to other medical and public health publications, but the fact that they appear under the imprint of an inter-governmental agency gives them a special character which must be fully appreciated if their nature and aim are to be understood. The mere issue under the imprint of an international organization, in which 81 governments are represented, bestows upon the publications sanction and weight which those published privately generally do not have. This also entails a different type and measure of responsibility on the part of the publisher. Before describing the publications themselves, the criteria which have to be applied in deciding what an international health organization should publish will be discussed.

Principles Governing Selection

While WHO publications may be difficult to distinguish from national publications, they have to meet certain requirements which set them apart. The chief requirement is that the publications should have international significance and that they should make a contribution to the improvement of health conditions in some area of the world.

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It is not easy to define what a publication of "international significance" is. From the point of view of WHO, a publication is lifted out of the class of local or national interest if the information which it contains is based upon experience in, or is important to, a fairly large number of countries. A study of cancer mortality, diphtheria incidence, or yaws prevalence throughout the world, or in a group of countries, is appropriate for publication by an international health organization. So are reports of expert groups, or symposia on specific subjects, since they represent the authoritative opinion and experience of outstanding workers from different countries.

This does not imply that a study must necessarily be concerned with a wide geographic area or appear under the authorship of experts from several countries to be considered as having international significance. For example, a paper which describes Lassen's[1] emergency method for dealing with bulbar and respiratory paralysis is of international significance because the method described has attracted the attention of clinicians and the public health authorities of several governments. Another example is Bowlby's[2] exhaustive report on the effects of the separation of the child from its mother. This work is internationally significant because the author

produced it after visiting many countries and making a thorough search of the literature. Then the manuscript of the book was circulated before publication to a number of experts in many countries. Their comments were taken into account before the book was given WHO's imprint.

The intergovernmental outlook which must be maintained in certain WHO publications is a two-edged sword. While the Organization is in a unique position to call upon outstanding specialists from many countries, it must not publish anything that might be incompatible with the views of member governments. It is the publication of papers which present individual viewpoints or philosophies that raises serious difficulties. The private publisher may issue a particular outline by one individual for the development of national health services. A government would usually publish such an outline under the technical responsibility of some constituted body, for it is preferable to issue collective rather than individual views under government sponsorship. This holds true for an international organization like WHO, with the added requirement that the collective view must also be reasonably representative of the opinions of authorities from other member countries.

That a publication should make a contribution to the improvement of health conditions in some part of the world is another important requirement. For example, the WHO monographs on BCG or yellow fever vaccination, or on the preparation and chemical and serologic control of cardiolipin antigens, are of general and practical value. Of equal value is the monograph "Malaria Terminology."[3] The latter encourages the unification of terms in malariology and facilitates the assessment and comparison of the results of malaria control in different countries.

Nature, Content, and Form

WHO publications can be considered under the headings of periodicals, and nonperiodic publications (books and pamphlets).

Periodicals

The *Bulletin of the World Health Organization* is the principal scientific periodical of WHO. Twelve issues, of approximately 150 to 200 pages each, appear annually and contain papers in either English or French, with a detailed summary in the alternate language. Certain issues of it are devoted to a specific subject such as: the control of endemic goitre; plague control; environmental sanitation; syphilis; rabies; therapeutic, prophylactic, and diagnostic substances; health statistics; yellow fever; malaria control; and tuberculosis. The *Bulletin* contains well-documented reports of previously unpublished findings and comprehensive reviews of the literature on a particular subject. It is therefore a periodical of interest mainly to the specialist.

The *International Digest of Health Legislation* is a quarterly publication intended only for those directly concerned with health legislation. Thousands of public health laws and acts which appear in official government gazettes in many languages are scanned regularly and often published in this periodical. Translations of selected texts are included complete or in extract form in the *Digest*. Some laws are simply mentioned as references. Comparative studies on health legislation in various countries appear from time to time. Such surveys have been made of laws concerning nursing, leprosy control, midwifery, and smallpox vaccination.

The *Chronicle of the World Health Organization* is published monthly in English, French, Spanish, and Chinese. This periodical contains information on the work of the Organization and summaries or reviews of other WHO publications. The *Chronicle* is the best source of regular information on new WHO publications.

The *Epidemiological and Vital Statistics Report*, published monthly since June 1947, contains statistics on notifiable diseases in various countries and in larger towns.

Annual Epidemiological and Vital Statistics is the only publication which offers detailed vital and health statistics for many countries of the world on a yearly basis.

Nonperiodic Publications

This group includes two series of fundamental importance to the work of the Organization: the "Technical Report Series" and the "Official Records," and a number of books and pamphlets.

The "Technical Report Series" consists of reports of expert committees, study groups, and other technical advisory bodies convened by the Organization to make available authoritative advice which may serve as the basis of many governmental and intergovernmental health programmes. The reports published cover an extremely wide range of subjects, including most of the diseases which are serious public health problems (for example, tuberculosis, treponematosis, malaria, poliomyelitis, influenza, rheumatic diseases, hepatitis, and many tropical diseases); insecticides; biologic standardizations; mental health; occupational health; nutrition; nursing; and other related subjects.

Reports of expert committees are not binding on either the Organization or the member governments; but, because of their membership, they do carry considerable weight and are found useful by public health departments in all member countries. Of all WHO publications, the reports of expert committees are perhaps the most truly international and the most representative of the work of WHO. They are also, on the whole, perhaps of the greatest practical value to the public health worker.

The "Official Records" contain the Annual Report of the Director-General, some working documents such as the Organization's programme and budget, and reports on meetings of the WHO governing bodies. They are essential working tools for the Organization; but, with the exception of the Annual Report of the Director-General, they are not of great interest to those who are not directly connected with international health work.

Most of the medical and public health books issued by the Organization appear in its "Monograph Series." Thus far, 39 titles have been published in this series, in either English or French or both; and a few more are added each year. Such monographs represent studies of specific problems, descriptions of special techniques, and comprehensive texts on certain diseases.

Examples in the first category are a study by L. Bovet[4] on the psychiatric aspects of juvenile delinquency, that of J. C. Carothers[5] on the African mind in health and disease, or that of J. M. Barnes[6] on the toxic hazards of certain pesticides to man.

In the second category, descriptions of certain laboratory and public health techniques, are included, for example, monographs on laboratory techniques in rabies, on milk pasteurization, or on the design and operation of septic tanks.

Examples of publications in the third category, comprehensive texts on specific diseases, are monographs discussing plague, influenza, donovanosis, and poliomyelitis.

It is hoped that eventually most of the diseases which are of real importance from the public health point of view may be covered in this series so that, in time, a complete library on such diseases may be made available for the use of public health services and workers.

Space permits only a passing reference to some of the other publications which appear in book and pamphlet form outside the "Monograph Series": the "Pharmacopoea Internationalis;" the "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death," of which tens of thousands of copies have been purchased by governments for their own use; and the "Manual of Specifications for Insecticides and for Spraying and Dusting Apparatus," which is being used by both consumers and manufacturers of insecticides and spraying apparatus.

WHO publications are available in a number of depository libraries throughout the world and can be purchased either from WHO, Geneva, direct, or through a bookseller from the sales agents listed on the back cover of all WHO publications.*

Conclusion

Among the more than half a million individual papers published annually in medical and paramedical journals and innumerable medical books, the contribution of WHO can represent only a very small fraction of the specialized knowledge made available every year. The size of this contribution is small in proportion to its significance.

WHO publications are the Organization's principal link, indeed the only effective medium of communication, with professional health workers. In his 1951 report to the Executive Board, the Director-General of WHO pointed out that "although the success of WHO depends on the support of governments, the Organization cannot hope to obtain satisfactory results without the full co-operation of the medical and public health professions . . . WHO will ultimately be judged by the practical results achieved . . . and the quality of scientific leadership it has provided . . . ; publications are a medium for reporting the practical achievements and providing the leadership."[7]

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*In the United States the WHO sales agent is the Columbia University Press, International Documents Service, 2960 Broadway, New York 27, N.Y. A catalogue of WHO publications can be obtained, free of charge, on request.

WHO's Sixth Year of Activity

In 1954, the World Health Organization completed its sixth year of existence and participated in 329 major health projects in 75 countries. At the same time, the Organization achieved good progress in the task of establishing standards for drugs and vaccines, in co-ordinating research, and in developing increased training facilities for health personnel.

These facts emerge from the 200 page Annual Report for 1954* which Dr. M. G. Candau, Director-General of the World Health Organization, submitted to the Eighth World Health Assembly in Mexico City in May.

The essential aim pursued by WHO in 1954 remained the strengthening of the permanent structure of public health services in its Member States, rather than short-term campaigns. Indeed, the fact that countries markedly increased their requests for WHO help in working out long-term plans for the development of their health services is considered by Dr. Candau, in his introduction to the Annual Report, as "the most encouraging aspect" of the requests received by the Organization last year.

Another important development, in the Director-General's opinion, is "the growing attachment of Member States to the idea of international co-operation, and their increasing readiness to undertake joint action in solving problems which affect more than one country." The Annual Report lists a number of such joint undertakings, among them the Inter-American Centre of Biostatistics in Chile, the Regional College of Nursing in Egypt, and the advanced course for waterworks engineers in Europe.

The Fight Against Disease

The most outstanding examples of WHO's role in co-ordinating national efforts occurred in the field of disease control. Thus in 1954, the American countries represented at the fourteenth Pan American Sanitary Conference at Santiago (which served also as the sixth session of the WHO Regional Committee for the Americas) agreed on a five year plan to eradicate malaria from the Americas as a whole. This campaign is to be based on national campaigns already under way, and on inter-country programmes assisted by WHO through the Pan American Sanitary Bureau working in the Caribbeans and Central America.

In general, malaria continued to occupy an important place in WHO programmes which included 20 different anti-malaria operations in 1954. In addition to the Santiago discussions, an inter-regional malaria conference in the Philippines brought together key personnel involved in the fight against this disease.

Treponemal and venereal infections were also the object of mass field programmes assisted by WHO in 20 countries. By the end of the year, more than 25 million people had been examined and 6 million treated with penicillin in the campaigns carried out in Haiti, Indonesia, Laos, the Philippines, Thailand, and Yugoslavia. The average cost of treatment fell below previous estimates to approximately $1.25 per patient treated, and $0.12 per person examined, including all national and international expenditures.

In tuberculosis control, WHO was at work in 28 countries last year, helping either with mass BCG vaccination campaigns (22 projects) or with TB teaching and training centres (18) or both. About 32 million people were tested with tuberculin during the year, and about 11 million of them were given BCG vaccination. International expenditure for the BCG campaigns has been borne by UNICEF, and the Children's Fund has also assisted materially in

Student health visitor weighing baby at health centre.

*The Work of WHO, 1954. Off. Rec. World Hlth. Org. No. 59, March 1955.

many of the malaria and treponemal campaigns mentioned earlier.

Veterinary public health and the fight against zoonoses was also a feature of WHO's programme against communicable diseases. WHO was especially concerned last year with the following: brucellosis (undulant fever), rabies, Q Fever, leptospirosis, animal tuberculosis, anthrax, and psittacosis.

Work on the virus diseases was broadened and integrated with the aim of bringing virological techniques into practical use for the diagnosis and control of diseases.

The WHO influenza laboratories continued their studies on the epidemiology of influenza viruses.

A WHO programme for the study of poliomyelitis has been developed; the intensive research on polio vaccines conducted in several countries has been carefully studied and the WHO report states that "prospects for eventual success are good."

WHO's work on trachoma control continued; the pilot project in Morocco (French Zone) was successful in preventing the annual epidemic of seasonal conjunctivitis. The Taiwan project was extended, and new schemes started in Egypt, Tunisia, and Yugoslavia. Surveys were made in India, Indonesia, and Spain.

WHO was active in control and research work concerning 30 other diseases, among them diphtheria, typhoid fever, onchocerciasis, leprosy, plague, cholera, yellow fever, smallpox, bilharziasis, and relapsing fever.

Health Services in the Field

In order to strengthen national health services, WHO helps to introduce essential measures and techniques into the permanent organization of the country. These measures depend on the level of development of the country, and of its health organization. The Annual Report contains many striking examples of the work carried out with WHO assistance in widely different areas:

Africa. The WHO Regional Office in Brazzaville was able to assist 12 countries and territories in 20 major health schemes. The emphasis remained on expanding campaigns against communicable diseases, particularly malaria and the treponematoses. Programmes for the control of tuberculosis, leprosy, and other diseases, and for the improvement of nursing, nutrition, maternal and child health, and environmental sanitation were also under way. "Nevertheless," says the Annual Report, "what has been done so far in Africa represents only a very small fraction of what still remains to be accomplished. In view of the very special conditions in the Region, studies still have to be carried out to determine the best methods to be used, before more extensive activities can be planned."

Last year, work was done in Bechuanaland, East Africa, French Africa, Kenya, Liberia, Nigeria, Nyasaland, the Seychelles, Somaliland Protectorate, Southern Rhodesia, Tanganyika, and Zanzibar.

Americas. In the Americas, there has been considerable progress in the development of public health services during recent years. This progress however, says the WHO Annual Report, must be assessed in relation to the expanding needs of a population which is increasing rapidly, especially in tropical areas.

The specific health problems have not changed: gastrointestinal infections and parasitic infestations are still widely prevalent and emphasize the need for better sanitation. The need for well-trained, adequately paid, and fully employed health personnel remains acute.

The Pan American Sanitary Bureau, WHO's Regional Office for the Americas, in Washington, was able to assist 20 countries with 58 different health schemes. Of these, no fewer than 17 were co-operative programmes of interest to several countries in the region. The Annual Report also mentions that governments in the Americas are allocating more funds to health work, and that normal government expenditure for routine health services is now approaching 10 percent of the total national budgets.

Aside from inter-country programmes, work was done in Bolivia, Brazil, British Guiana, British Honduras, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Leeward Islands, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad, and Windward Islands.

Southeast Asia. The WHO Regional Office in New Delhi is responsible for an area comprising Afghanistan, Burma, Ceylon, India, Indonesia, Nepal, and Thailand, and in these 7 countries was able to assist 66 health programmes last year. Since 85 percent of the population of Southeast Asia live in rural areas and have a low standard of living, the essential need is to provide basic health services in rural areas.

Governments are organizing various kinds of rural health units, and WHO has been able to assist with programmes for maternal and child health, control of communicable diseases, and for training of health personnel. These programmes are being integrated into the general public health services.

Europe. European countries have varying individual patterns of health services but nevertheless form a region more uniform than any of the other WHO regions. As a result, the WHO programme has been concentrated on activities which interest several or all of the countries in the region.

There were individual health projects in 10 countries only, but of the 62 schemes organized by WHO last year, more than half were inter-country programmes. Typical projects dealt with nursing, health education of the public, school health services, alcoholism, training of personnel in environmental sanitation, and in anaesthesiology.

The WHO Regional Office remained temporarily located in Geneva, pending its removal to Copenhagen for which no definite date can yet be fixed.

Eastern Mediterranean Region. From Alexandria, the WHO Regional Office runs a programme designed to improve public health administration, to control communicable diseases, and to increase the number of health personnel. Seventy-two health schemes dealt with these broad categories of the programme and involved direct assistance to 14 countries: Cyprus, Egypt, Ethiopia, Iran, Iraq, Israel, Jordan, Lebanon, Libya, Pakistan, Saudi Arabia, Sudan, Syria, and Yemen.

An important scheme is being developed to achieve malaria eradication in a group of five countries: Iran, Iraq, Lebanon, Syria, and Jordan. They form a more or less isolated bloc stretching from the eastern shores of the Mediterranean to the desert and mountainous border of Pakistan. In ancient times, much of this area was irrigated and very fertile; but severe and widespread malaria has depopulated the country. The WHO Annual Report states that the inter-country programme envisaged "may lead, within the foreseeable future, to the elimination of an ancient scourge from a group of countries whose population totals some thirty-two millions."

Western Pacific. The WHO Regional Office in Manila participated actively in the health work of the following countries and territories: Brunei, Cambodia, China (Taiwan), Fiji, Hong Kong, Japan, Laos, Malaya, North Borneo, Philippines, Sarawak, Singapore, and Viet Nam, with 42 projects. Many of these are in nursing, mother and child health, and midwifery training, as well as in the control of malaria, yaws, and tuberculosis. As in other regions, the shortage of medical, nursing, and auxiliary personnel is acute, and much emphasis is given to training schemes.

Nurse of WHO/UNICEF team giving hygiene lesson in India.

Training and Education

Approximately 40 percent of all health projects assisted by WHO last year were training programmes designed to meet the critical shortage of all categories of health personnel. So far, since its inception in 1947, WHO has awarded over 4,500 fellowships, of which 667 were in 1954. The tendency is to place a high proportion of Fellows for study within their own region. In 1954, regional fellowships accounted for 68.2 percent of the total awarded. Aside from obvious savings in travel costs, these regional fellowships have the advantage of enabling students to learn under conditions similar to those in their own countries, so that the process of adapting their acquired knowledge to their home environment is easier.

Financial Position and Collaboration With Other Agencies

The regular budget of WHO in 1954 amounted to $8,500,000. In addition, 128 health projects directly involved in the economic development of various countries were made possible by an allocation of $3,977,400 from the U.N. Technical Assistance Funds. Joint work with UNICEF continued in all fields relating to the health of children. WHO also co-operated with FAO in nutrition,

meat hygiene, and zoonoses; with UNESCO on fundamental education; with ILO on occupational health activities and on the hygiene of seafarers; and finally, with ICAO, on the sanitation of airports.

New Challenge

In his introductory remarks to the Annual Report, Dr. M. G. Candau mentions briefly a new challenge which faces the Organization as a result of the modern discoveries of science and medicine. "It has indeed become increasingly clear in recent years that, sooner or later, WHO would have to assume responsibility for assessing the possible effects on health of the unprecedented interference with natural processes now occurring over large areas of the world. For example, to what extent is the balance of nature being affected by the wholesale destruction of insects? What will be the long-term results of the extensive use of antibiotics? How will the disease patterns of a population be influenced by the intense efforts now being made to raise the standards of environmental sanitation and of hygiene in general? How important is the contamination of the air, soil, and water caused by the increased use of atomic energy?

"The study of this last problem acquired emphasis, by the end of 1954, as a result of a decision taken by the United Nations General Assembly to invite WHO to participate in an international conference which is to examine the peaceful uses of atomic energy. Thanks to the contributions of four experts, who advised WHO on the role it could play in this field, I am confident that the plans submitted to the Executive Board and to the Eighth World Health Assembly will make it possible for the Organization fully to assume its new responsibilities in the domain of atomic energy in relation to medicine and public health. In so doing, the Organization will remain faithful to its constitutional obligations, the essence of which is to ensure, through co-operation and mutual aid between countries, health, prosperity, and peace to all mankind."

"THE ADVENTURES OF A BLUEBOTTLE"

In a miniature Paris studio complete with minute spotlights of less than 4 watts mounted on a bridge, one of the most remarkable films of the year has been produced starring Calliphora Erythrocephala. A documentary picture made by a French scientist, Dr. Pierre Thevenard, it was premiered recently before a group of scientists as the first successful example of "radiocinematography," or filming with x-rays. After previous attempts in the United Kingdom and Germany had failed, Dr. Thevenard, of the Pasteur Institute in Paris, decided to pursue the experiments and to produce a 35 mm. film on the biological history of the bluebottle. Special camera equipment had to be assembled with strong magnifying power and a recording range of between 24 pictures a second and one picture every ten minutes. By means of irradiation through the aperture, and without either fluorescent screen or lenses, Dr. Thevenard was able to study the metamorphosis of the insect and the processes involved in the passage of food through its body. Unlike ordinary microphotography, x-ray filming retains the three dimensions. To obtain the shots the miniature construction was necessary.

Apart from its high artistic quality, "The Adventures of a Bluebottle" emphasizes the exceptional value of radiocinematography as an instrument for scientific research. The various phases of the metamorphosis revealed by the x-rays provide evidence of hitherto unknown phenomena. (UNESCO)

Oldest University in America

THE UNIVERSITY OF SANTO DOMINGO, oldest in the Americas, is located in the modern University City, whose buildings occupy an area of 300,000 square meters on the outskirts of the city.

The acres of colorfully landscaped gardens will eventually include 61 superbly designed buildings to house the University's various schools. These buildings give little indication of the battles and intrigues which have raged about their doors for many centuries.

In 1538, when Pope Paul III granted the right, by Papal Bull, to establish the first university in the Western hemisphere, he allowed the Franciscans only four schools: Theology, Law, Medicine, and the Arts. The original buildings were part of the Cathedral of Santo Domingo.

The University of Santo Domingo was founded on October 28, 1538, by Monjes of the Order Dominicos. According to the historians, this edict really converted the Estudio, which the Dominicos Fathers had sustained in the old "Spain" since 1510, into a university.

The University obtained the same privileges given to the University of Alcala de Henares, in Spain; the edict authorized the University to graduate in different faculties both religious aspirants as well as secular, and it was named Royal and Pontific University of Santo Tomas De Aquino.

It should be mentioned that the college of the Dominicos was not the only one to come under the category of university at that time. In 1550, a school was founded, endowed by philanthropist Hernando de Gorjon whose memory is honored by the Dominicans, and it was given the name of University of Santiago de la Paz, thus increasing the fame of the colony, known in those days as "the Athens of the New World." This second university eked out a precarious existence until 1767, the year in which the Jesuits were expelled from the Spaniola dominions; the university was transformed later into a seminary which still exists, and where the national clergy are prepared.

The first great setback suffered by the courageous monks was the sacking of the city by Admiral Sir Francis Drake in 1586. All the precious archives of the University were destroyed by Drake's pillaging sailors and the monks themselves were forbidden to teach. Again the doors were closed by order of the Haitian General Toussaint L'Ouverture when his forces overran the island for the French. Not until 1815, when the French were vanquished by the Spaniards, was teaching permitted again.

For seven years, the University struggled against lack of funds, only to be completely destroyed by the army of Haitian President Boyer in 1822. From then until 1844, 78 years later, the longest period of inactivity in its history, the teaching fathers were forced to hold clandestine classes in secret meeting places all over the city.

It was not until 1882, 38 years after, that the government finally subsidized education. In addition, a campaign got under way to enlist private aid; most of the island's wealthy patriots subscribed heavily as a consequence, and the University has never suffered since for want of finances. During the third colonial period of the Spanish government, Dr. Jose Nunez de Caceres directed the University, converting it into a public establishment, separating it from the religious ties of the Jesuits. The prestige of this cultural center extended throughout the neighboring lands of Spanish America, and students from the Antillas and mainland hastened to it. Among them were graduates as eminent in the arts as in the sciences.

From this celebrated University were graduated professors and rectors for other universities of Spanish America, who were called to the lecture rooms of the universities created in Caracas and Habana in the eighteenth century.

In 1914, the college was formally renamed Santo Domingo, and re-chartered with departments of law, political science, medicine, natural science, mathematics, English journalism, and architecture.

During the American Occupation from 1916 to 1934, many U.S. Marines attended the courses and received degrees.

This old University has space for only 1,000 students. Before 1914, no woman studied in this University. The first woman graduated Doctora in Medicine was Miss Evangelina Rodriguez Perozo, in 1919. Some years later, Miss Ana Theresa Paradas was graduated as a lawyer, and Miss Sophia Oliva as a midwife. In 1928, Miss Mercedes Heureaux was graduated Dra. in Medicine, the second and last woman graduated in medicine from the old University that was completely destroyed by cyclone in 1930.

—MERCEDES A. HEUREAUX, M.D.

NEWS FROM THE BRANCHES

Branch Fourteen, New York, New York

The fall meeting of the Women's Medical Association of New York City was held on November 3, 1954. Dr. Thomas W. Stevenson, attending surgeon, Presbyterian Hospital and clinical professor of surgery, Columbia University College of Physicians and Surgeons, spoke on "Plastic Surgery of the Face and Neck." "Plastic Surgery of the Cleft Palate" was the subject of a talk by Dr. Arthur J. Barsky, plastic surgeon to Mount Sinai Hospital, Beth Israel Hospital, Bronx Hospital, and Morrisania Hospital. Dr. Josephine M. Abelson discussed "Deformities of the Jaw and Their Correction," and Dr. Ida M. Golomb, diplomate of the American Board of Peridontology, instructor in the Department of Stomatology, Columbia University Dental School, and chief of Department of Periodontia, New York Infirmary, talked on "Tumors in the Oral Cavity." Dr. Rosa Lee Nemir was the moderator of this round-table discussion.

On May 4, the spring meeting was held. The program included two speakers. Dr. Ruth Fox, president of the New York City Medical Society on Alcoholism and vice-president of the National Committee on Alcoholism, chose as her subject "Treatment of Alcoholism." "Interaction of Some Psychological and Constitutional Factors in Personality Development," illustrated by the movie film "Two Children," was discussed by Dr. Margaret Fries, psychoanalyst, trustee of the New York Psychoanalytic Institute, attending psychiatrist at Hillside Hospital, and consultant at the New York Infirmary.

The fifth presentation of the annual awards for scholastic excellence were made to fourth year women students of each of the medical schools in the City of New York.

After the program, a business meeting and election of new members was held. Since last fall, 18 new members have been accepted into the society. There have been five meetings of the board of directors and executive and acting committees.

Branch Eleven, Southwestern Ohio

On May 10, 1955, a dinner meeting of the Medical Women's Club was held. Following the dinner, Dr. Aurelia McIntyre gave a travelogue.

Branch Four, New Jersey

On March 27, a meeting was held in Newark. Gen. Elbert De Coursey spoke on "Peacetime Uses of Atomic Energy." All other professional groups and many civic organizations received invitations to this lecture. A movie entitled "A is for Atom" was also shown.

A lecture on a phase of antibiotic research was given in New Brunswick on May 18, by Dr. Hubert Lechevalier, an associate of Dr. Selman Waksman of the Institute of Microbiology. At that time, the members of the New Jersey Branch were taken on a tour of the Institute.

REPORTS FROM COMMITTEES

HISTORICAL INFORMATION

THE PROJECT of obtaining medical profiles of pioneer medical women is slowly beginning to be put into effect. Mrs. Majally has had a letter from Dr. Margaret N. Kleinert of Boston reporting recorded interviews with Dr. Marianna Taylor, Dr. Alice Bigelow, and Dr. Isabel Kerr.

The obtaining of historical data, its use in programs when possible, and its safe keeping continue to be our aims. The writing of medical autobiographies as well as the writing of historical records such as:

Women in Medicine — Esther Pohl Lovejoy, M.D.

These Were The First—Elizabeth Bass, M.D.

Pioneer Medical Women of the Southwest—Antoinette Le Marquis, M.D., are very important and should constantly be brought to the attention of the Association, as well as the writing of more popular medical books, like Dr. Emily Dunning Barringer's "Bowery to Bellevue" (Norton).

Not only books but also pamphlets, essays, and articles dealing with medical histories are valuable in creating an available body of information about the opportunities and achievements of women in medicine. The personal biographies in the JOURNAL are of great interest and value.

—GULIELMA F. ALSOP, *M.D., Chairman*
Historical Committee

American Medical Women's Association

PRESIDENT'S MESSAGE

THE FOURTH OF JULY is a wonderful holiday in the United States. When we are children, we think of it as a day for picnics, fun, and celebration. We learn, early in life, that we should be joyous because July 4, 1776, was the day of the signing of the Declaration of Independence, the birthday of our nation. When we grow older, we think more seriously of the real meaning of the words and phrases in that document and we realize that although freedom is truly wonderful, each of us has a certain responsibility to preserve that freedom and uphold the principles set forth in the Declaration of Independence.

Recently, I went to a Civil Defense meeting for the administrative personnel of first aid stations. I came away feeling that perhaps the lethargy that exists in many communities results from too much talk on the higher levels and very little action at the level of the ordinary citizen. I believe that the average citizen is willing to do something about civil defense, but is confused about just what he should or can do, and is waiting for some definite word from the administrators of this program. The individual citizen needs to be given a specific job and trained for that job immediately, not in one, two, or three years from now. Many of them have taken first aid courses when it was possible for them to do so, but there are still many who have done nothing and are just waiting for guidance. It would be simple enough for a group of potential litter bearers to get together to learn how to improvise litters out of poles and blankets, or doors. It would be simple enough for the food officer and the volunteer cooks to get together and discuss the preparation of food for survivors in an improvised kitchen and to learn about decontamination of foods and water. Many of those who have shrugged their shoulders in despair at the thought of an atomic bombing would be more than willing to prepare themselves for some job now that the results of operation "Q" indicate that there may be survival in properly constructed shelters. I believe that we, as physicians, have a very important part in the Civil Defense program. The opinion of the physician is respected and influences greatly the thinking of others. Should we be bombed, the physicians will be expected to perform the herculean task of tending the wounded and dying. A little orderly preparation would certainly facilitate this task. If we are going to protect the ideals set forth by the Declaration of Independence, we must all take an active part in the Civil Defense program as well as in government affairs. Perhaps there is not much lethargy in your community, but if there is, you as a physician and an individual can do something about it.

Esther C. Manning

P.S. Don't forget about electing a Medical Woman of the Year from your area to be honored at the Mid-Year Meeting in November. Why not plan to come to the Mid-Year Meeting? Cincinnati is easy to get to and is very close to the population center of the United States. The women physicians in this area will do their very best to assure you a good time. You do not need to be an officer or a committee member to attend. Why not mark off November 11, 12, and 13, 1955, on the calendar today?

Opportunities for Women in Medicine

SCHOLARSHIPS

In 1930, the Commonwealth Fund (New York) established a series of scholarships in three schools, for students who would agree to locate in rural areas for a period of at least three years after completion of medical school and internship training. The three schools were located in Boston, Nashville, and New Orleans, and the arrangements made were generous. Students received $1,200 for each of the four years and after internship were generally assisted in equipping an office. The intended purpose was to remove all financial obstacles from the path of the student who professed to be interested in rural practice. Among more than 50 students selected at one of the three schools, there were a few scholastic failures, and one or two chose to release themselves by repayment of funds; but the great majority met the terms of the agreement and did practice for at least three years in a rural community. In steering these students, it was found that the type of internship called for was sometimes difficult to arrange and needed some control. It was then believed that both obstetrics and pediatrics were important parts of rural practice, an assumption no longer universally held. Whatever the content of the internship selected, the hospital's example of medicine as it is being practiced is more impressive to the young physician than that of the medical school.

State of Alabama county scholarships are issued to students who are in financial need, are residents of a county in the state, and are registered in the Medical College of Alabama. Of course, most of the counties of Alabama are essentially rural; a scholarship may be granted to one resident in each county, the maximum amount being $1,600 over the four year period. Mandatory repayment is in the form of practice in the county of which the applicant is a resident for a period that is variable but is not to exceed five years.

The Illinois Agricultural Association, in co-operation with the Illinois State Medical Society, maintains a student loan fund for residents of counties in Illinois where physicians are needed. The maximum loan for a year is $1,000, and the maximum total loan is $5,000. The recipients must practice general medicine in communities of less than 5,000 population in their home counties until the loan is repaid in full. This program has been in operation since 1947, and there are now about 60 participating students and doctors. Most of the doctors are still in service.

The Iowa State Medical Society Educational Fund is available for loans to Iowa residents, both medical students and interns, the total maximum amount being $6,000. The recipients must practice medicine in a rural community in Iowa for at least three years. Repayment of the loan is mandatory, beginning with the third year in practice. About 20 students are now participating.

The Kentucky State Medical Association sponsors a loan fund from which $800 a year is available to medical students, preferably at the University of Louisville, who will agree to practice for as many years as financial aid is extended in communities of less than 10,000 population, selected on the basis of medical need. Repayment is mandatory, with interest, after a year of practice. About 70 students and graduates are now participating, and about 20 are now in active practice. At least six have completely fulfilled their financial and moral obligations. This fund has been in operation since 1946.

The Michigan Foundation for Medical and Health Education, Incorporated, offers loan funds to residents, interns, and senior medical students in Michigan's two medical schools who will agree to practice in a community of less than 5,000 population for a minimum of three years. Repayment is required, beginning a year after the graduate enters practice. The Foundation is supported by contributions from Michigan doctors.

The Minnesota State Medical Association has established a fund that provides outright grants of $1,000 a year for four years to medical students who will agree to practice in a community of 5,000 population or less in Minnesota for a period of five years. The program is restricted to the University of Minnesota Medical School.

The Mississippi State Medical Education Board administers a scholarship plan that has already placed a great many doctors in active rural practice. The student agrees to practice a minimum of two years in a rural area; repayment is by service, each year of practice in the designated area reducing the loan by a fifth. Since this program was initiated, no white or Negro medical student who was qualified to enter an approved medical school has been denied

that opportunity for lack of money. In the future, Mississippi can expect an annual supply of 50 physicians through this program, and since the attrition by death of past six years has averaged about 40, the scholarships alone will more than offset the loss. The funds are appropriated by the legislature.

The Ohio State Medical Association provides a scholarship for Ohio rural residents of $500 per year, in return for which rural practice is "encouraged." No repayments are required. At the time of writing, there were only five participants.

PHYSICIANS WANTED

The Military District of Washington has vacancies for civilian medical officers to work in the Washington, D.C., area at $7,040 to $9,360 per annum. Vacancies are U.S. Civil Service positions in the fields of general medicine and surgery, internal medicine, pediatrics, and obstetrics and gynecology with the Civilian Employee Health Service of the Department of the Army. Applicants must have the degree of Doctor of Medicine and have completed internship or residency in a specialty, except that active duty as a commissioned medical officer with the Veterans Administration may be substituted for the required internship. Except in the case of retired medical officers of the military or Public Health Service, applicants must possess a current license to practice medicine and surgery in a state or territory of the United States. For information, write or phone the Civilian Personnel Office, Military District of Washington, Washington 25, D.C.; telephone Liberty 5-6700, extensions 56312 or 79027.

* * *

The Department of Correction, City of New York, has an opening for a physician part time, and a second position for a physician full time in its women's prison, the house of detention. Further details and information can be obtained from Rose C. Boyer, M.D., Medical Director, Department of Correction, City of New York, 100 Centre St., New York 13; telephone Rector 2-6200, ext. 245.

PICTURE CREDITS

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MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

The next Council Meeting of the MWIA will be held in 1956 at the Hotel Bürgenstock, Lucerne, Switzerland, September 21-23.

The next Congress will be held the week beginning July 14, 1958, at Bedford College, Regent's Park, London, England.

RESIDENCIES

The new University of California Medical Center in Los Angeles plans to offer a residency training program in psychiatry, beginning in July. Two second year residents will be appointed to the center's psychiatric inpatient and consultation services and four first year residents, initially, to the psychiatric outpatient clinic. The medical school portion of the center is already in use, and the 320 bed teaching hospital has opened. Plans are being made for the construction of a 248 bed neuropsychiatric institute, to be built as a wing of the new medical center. The institute will include the following facilities: beds for child, adolescent, and adult psychiatry, neurology, and neurosurgery; an outpatient clinic for undergraduate and graduate training programs in psychiatry and allied disciplines; a neuropathology laboratory and museum; and research laboratories. It will be operated jointly by the state department of mental hygiene and the University of California.

HEART DISEASE RESEARCH

Applications by scientific investigators for support of research to be undertaken during the year beginning July 1, 1956, are now being accepted by the American Heart Association.

The application deadline for research fellowships and established investigatorships is September 15, 1955 (See May JOURNAL). Applications for grants-in-aid must be made by November 1, 1955, a month earlier than in previous years.

Funds to support Heart Association research projects in the cardiovascular field are provided from public contributions to the Heart Fund.

Grants-in-Aid are made to experienced investigators to provide support for specific projects. Grants are made in varying amounts, not to exceed $10,000.

Further information and application blanks may be obtained from The Medical Director, American Heart Association, 44 E. 23 Street, New York 10.

AWARDS

Announcement is made of the United States government awards for the academic year 1956-1957, authorized under the Fulbright act and presented under the auspices of the Department of State and the Board of Foreign Scholarships. Awards are available for university lecturing and advanced research in Australia (March-December 1956); Burma (June 1956-March 1957); Ceylon (June 1956-March 1957); India, subject to availability of funds (July 1956-April 1957); New Zealand (March-December 1956); the Philippines (June 1956-April 1957); and Thailand (May 1956-April 1957). Applicants must be United States citizens. Those applying for lectureships are expected to have at least one year of college or university teaching experience in the United States or abroad. Applicants for research awards are expected to have a doctoral degree from a recognized institution of higher learning in the United States or abroad at the time of application, or recognized standing in their respective professions. Candidates for the doctoral degree or those expected to obtain it in the normal course of their training should apply to the Institute of International Education, 1 E. 67th St., New York. The 1956-1957 programs for Austria, Belgium and Luxembourg, Denmark, Finland, France, Germany, Greece, Iraq, Italy, Japan, Netherlands, Norway, the United Kingdom and colonial dependencies, and, subject to the availability of funds, for Egypt, Pakistan, and Sweden will be announced in July, although applications will be accepted from May 1 through the closing date, Oct. 1, 1955. Application forms and additional information are obtainable from the Conference Board of Associated Research Councils, Committee on International Exchange of Persons, 2101 Constitution Ave., Washington 25, D.C.

PAN AMERICAN MEDICAL ASSOCIATION

The next and Tenth Inter-American Congress of the Pan American Medical Association will be held in Mexico City. The scientific sessions will begin on Monday, March 25, 1957, at 9 a.m. The Congress will be held in sections covering all branches of medicine and surgery. There will be medical moving pictures, panel discussions, and scientific and technical exhibits. The Association has 42 medical sections including the new section of general practice.

Four days will be devoted to scientific sessions and the next three days will be spent in sight-seeing, with visits to Cuernavaca, Taxco, and Acapulco. Monday and Tuesday of the following week, medical meetings will be held in Guatemala City in conjunction with the local chapter there.

A large number of physicians are expected to attend from all of the Latin American countries as well as from the United States and Canada.

For further information write: Dr. Joseph J. Eller, Executive Director, 745 Fifth Ave., New York, N.Y.

PEDIATRICS IN PUBLIC HEALTH

The American Public Health Association, Inc., of New York announces the following vacancies in the field of pediatrics in public health. In each case, the position would be for the director of the maternal and child health activity of the organization indicated:

Connecticut State Health Department. Salary about $8,000. For further information write Stanley H. Osborn, M.D., State Commissioner of Health, Hartford 6, Connecticut.

Minneapolis City Health Department. Salary is $9,600. Contact Carl R. Lundeberg, M.D., Health Department, 401 City Hall, Minneapolis, Minn.

Minnesota State Health Department. Salary is $8,580 to $9,540. Write Mr. William E. Bender, Minnesota Civil Service Department, 122 State Office Building, St. Paul, Minnesota. (This position is that of pediatrician rather than director of the service.)

Wayne County Health Department. Salary about $10,000. Write H. Cadwell, M.D., Wayne County Health Department, Eloise, Michigan.

FELLOWSHIPS

A fellowship in pediatric neurology is available in the Children's Division of the Cook County Hospital under the auspices of the Dr. Julian D. Levinson Memorial Research Foundation; stipend, $5,000 per year. For information contact Dr. Abraham Levinson at Cook County Hospital, 1825 W. Harrison St., Chicago 12.

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The Raymond C. Henyan fellowship at Duke University School of Medicine, Durham, which is part of a large research project in neurosurgery at Duke under the direction of Dr. Barnes Woodhall, has been renewed for 1955.

MARJORIE BENNETT, M.D., F.A.C.A.

Dr. Marjorie Bennett of Winnipeg, Manitoba, Canada, has recently concluded a year as president of the Federation of Medical Women of Canada.

She is outstanding in the field of anaesthesiology. Her ambition had always been to study medicine and her education was directed toward this end. Dr. Bennett received her early education at Saskatoon, Saskatchewan. In 1932, she received her B.Sc. degree from the University of Saskatchewan, and her M.D. from the University of Manitoba in 1935. After postgraduate studies at home and abroad, she entered general practice in Winnipeg. This field of endeavour she pursued until 1944. In the meantime, she was anaesthetist at Winnipeg Grace Hospital. In March 1943, she received her Canadian certification in anaesthesia, and the following year was appointed to St. Boniface Hospital as anaesthetist, where she serves as chief of anaesthesia at the present time. In 1949, she became a Fellow of the American College of Anaesthesiologists.

The Winnipeg anaesthestists have followed the lead of such groups in other centers of the United States and Canada in organizing themselves into clinical groups. Dr. Bennett has done much to forward this organization in Canada, and she now heads such a group, known as the St. Boniface Anaesthetic Clinic.

In 1951, Dr. Bennett spent some time visiting outstanding anaesthetists in other countries in connection with her attendance at the twenty-sixth International Congress of Anaesthesiologists. She was accompanied by Dr. Dorothy Barnhouse. They visited outstanding hospitals and anaesthetists in London, Edinburgh, Glasgow, Paris, and Stockholm; and were greatly impressed by such men as Sir John Gillies of Edinburgh and Dr. Forster Gordh of Stockholm, Sweden.

Dr. Bennett has given of her time and executive ability to local medical societies. She has served as president and secretary of the Manitoba branch of the Canadian Anaesthetists Society and as secretary and treasurer, Winnipeg Medical Society.

Hobbies and other outside activities have not been neglected. As an undergraduate student, Dr. Bennett was interested in the Student Christian Movement; in sports, particularly swimming; and in the musical activities of the university. She takes an interest in many philanthropic associations in Winnipeg. Music, reading, and travel are her main interests. But she is also interested in amateur photography and enjoys this pastime. On a fine Sunday afternoon, she may be seen on the golf course with her 13 year old adopted son.

From one who knows her well and has been privileged to call her friend comes this comment, "Dr. Bennett is well liked, a woman of integrity, and a true friend."

—Ruth A. Johnstone Harvey, M.D.

ISABEL I. THOMAS DAY, M.D., R.R.C.

Dr. Isabel Thomas Day was an outstanding woman and a very much beloved physician and surgeon in her adopted home, Vancouver, British Columbia.

Born in Toronto, she received her education in that city and obtained her B.A. degree from the University of Toronto. Canada was involved in World War I, and Isabel served as a V.A.D. She served with the British Army in France and for her outstanding services received the Royal Red Cross medal, which was presented to her by King George V.

She returned to Canada following the war. But a life of ease did not satisfy her, and she decided to study medicine. She entered the University of Toronto Medical College where she distinguished herself by winning the Silver Medal on graduation. She was the first woman to earn membership in the honor medical fraternity, A.O.A., of the University of Toronto. As an undergraduate student, she entered into athletics and occupied executive posts. In her graduating year, she was president, Medical Women's Undergraduate Association.

In June 1924, she married Edward Bliss Day. After graduation in 1926, she and her husband moved to Vancouver where she practised, specializing in obstetrics and gynaecology. With the exception of periods of postgraduate studies in Toronto and Chicago, she continued to practice in Vancouver until her death in August 1953.

During her 25 years of practice in Vancouver, Dr. Day endeared herself to thousands of people. She gave unsparingly of herself to patient and friend. In her quiet manner, she brought courage, comfort, and knowledge to the bedside.

She took an active part in the medical life of the city. She was a member of staff of the Grace Hospital. For 16 years, she served on the staff of the outpatient department at the Vancouver General Hospital, working with Dr. G. F. Strong. For 15 years, she was medical adviser to the Victorian Order of Nurses. For many years, she gave freely of her time and energy to the work of the St. Johns Ambulance and the Children's Aid Society.

One of Dr. Day's hobbies was fishing. She looked forward to her summer holidays when she would don her high boots and go into northern British Columbia. There, in quiet with nature, she gathered new strength for the many problems she undertook in her daily work. One could not know her without feeling that you too had gathered from her some of that strength.

—Ruth A. Johnstone Harvey, M.D.

News of Women in Medicine

The AMA Convention

Many women physicians read scientific papers before the various sections of the AMA. The titles of the papers and their authors were: "Morphology of the Newborn Infant's Lungs, as Related to Distensibility, Blood Supply, and Gas Exchange," Dr. Edith Potter, Chicago; "Tissue Culture Methods Used in the Isolation of the Unknown Group of Eye Viruses," Dr. Ann Fowle, Dr. Anne Cockeram, and Dr. H. L. Ormsby, Toronto, Canada; "Diamox and Intraocular Fluid Dynamics," Dr. V. Everett Kinsey, Dr. Enriqueta Cmacho, Dr. Gerard Cavanaugh, Dr. Marguerite Constant, and Dr. Daniel A. McGinty, Detroit; "Role of Inactivity in Production of Disease: Hypokinetic Disease," Dr. Hans Kraus, Dr. Bonnie Pruden Hirschland, and Dr. Kurt Hirschhorn, New York; "The Use of Cytology as a Prognostic Aid to Treatment of Carcinoma of the Cervix," Dr. Ruth M. Graham, Boston; "Epileptic Equivalents in Childhood," Dr. Frederic T. Zimmerman and Dr. Bessie B. Burgemeister, New York; "The Role of the Pediatrician in the Hospital Care of the Orthopedically Handicapped Child," Dr. Helen M. Wallace, Dr. Roberts S. Siffert, and Dr. Jerome S. Tobis, New York; "External Electric Stimulation of the Heart in Adams-Stokes Disease, Reflex Standstill, and Unexpected Circulatory Arrest," Dr. Paul M. Zoll, Dr. Arthur J. Linenthal, Dr. Leona R. Norman, Dr. Milton H. Paul, and Dr. William Gibson, Boston; "Clinical Applications of Human Intramural Electrocardiography," Dr. Myron Prinzmetal, Dr. Rashid A. Massumi, Dr. Louis Rakita, Dr. Alfred Goldman, and Dr. Lois Schwartz, Los Angeles; "Benign Lesions Simulating Bone Tumors," Dr. Vincent P. Collins and Dr. Lois Cowan Collins, Houston, Texas; "Studies on the Visual Toxicity of Methanol: Additional Observations on Methanol Poisoning in the Primate Test Object," Dr. Albert M. Potts, Dr. Julius Praglin, Dr. Irene Farkas, Dr. L. Orbison, and Dr. Donald Chickering, Cleveland; "Promacetin in the Treatment of Dermatitis Herpetiformis," Dr. Maurice J. Costello and Dr. Constance Millette Buncke, New York; and "Industrial Ophthalmology as of 1955," Dr. Hedwig S. Kuhn, Hammond, Indiana.

Many women physicians presented exhibits: "Prophylaxis of Nonhemolytic Transfusion Reactions: Value of Pyribenzamine," Dr. C. R. Stephen, Dr. Ruth C. Martin, and Dr. M. Bourgeois Gavardin, Duke Hospital, Durham, N.C.; "Cleft Palate Program," Dr. Herbert Conway, Dr. Richard B. Stark, and Dr. Senta Jensen, New York Hospital-Cornell Medical Center, New York; "Seborrheic Dermatitis and Atopic Dermatitis (Eczema) in Infancy and Childhood," Dr. Jerome Glaser and Dr. Marylin F. Smelzer, University of Rochester School of Medicine and Dentistry, and Genesee and Strong Memorial-Municipal Hospitals, Rochester, New York; "The Use of Dihydroxy Aluminum Ammoacetate in Peptic Ulcer," Dr. J. Alfred Rider, Dr. Leo Van Der Reis, Dr. John O. Gibbs, Dr. Joyce Swaber, and Dr. Jennie Lee, University of California School of Medicine, San Francisco; "Psychiatric Services in General Hospitals," Dr. Lucy D. Ozarin, Veterans Administration, Washington, D.C.; "Prednisone and Prednisolone: Comparative, Clinical and Metabolic Evaluation," Dr. Laurance W. Kinsell, Dr. George D. Michaels, Dr. Marjorie Coelho, Dr. Nadine Foreman, and Dr. Roger W. Friskey, Institute for Metabolic Research, Oakland, California; "Structure and Dynamics of the Human Epidermis," Dr. Hermann Pinkus and Dr. Catherine Heise Steele, Detroit Institute of Cancer Research and Wayne University College of Medicine, Detroit; "Clinical Evaluation of Bone Marrow Spreads and Bone Marrow Sections," Dr. Harry Agress, Dr. Ann Lockhart, and Dr. Harry N. Offield, Veterans Administration and Jewish Hospitals, St. Louis; "Photocolposcopy," Dr. Leopold Z. Goldstein, Dr. Edward Viner, Dr. Harry B. Roitman, and Dr. Lillian Balter, Albert Einstein Medical Center, Southern Division, Philadelphia.

Annual Meeting of the Medical Society of the State of New Jersey

"The Role of the Endocrine Glands in Dermatology," was presented by Dr. Rita S. Finkler, chief emeritus, Department of Endocrinology, Beth Israel Hospital, Newark; "General Aspects of Vascular Disease," was discussed by Dr. Camille Mermod, attending physician, St. Barnabas Hospital, Newark; and "Recent Advances in the Treatment of Medical Complications of Obstetrics and Gynecology," and "Treatment of Diabetes," were topics discussed by Dr. Pricilla White, physician, Joslin Clinic, Boston, Massachusetts.

Among the exhibits presented by women physicians were: "Functional Uterine Bleeding," Dr.

RITA S. FINKLER, Dr. Edward Diamond, and DR. SYLVIA F. BECKER, Beth Israel Hospital, Newark; and "Clinical Effects of a New Steroid (Meticorten®) in Intractable Rheumatoid Arthritis," Dr. John W. Gray, DR. EVELYN Z. MERRICK, and Dr. Edward Henderson, Hospital Center, Orange, and St. Barnabas Hospital, Newark.

New England Hospital

DR. DORCAS H. GUEST of the Department of Anesthesiology was a guest speaker at the New England Hospital Assembly on March 29. Her subject was "Cortisone Therapy and Acute Adrenal Insufficiency in Relation to Anesthesia."

DR. ANNELLA BROWN, chief of surgery, DR. ALICE LOWELL, chief of medicine, and Dr. Alfred Solow, proctologist, all of NEH, took part in the seventh annual teaching seminar of the International Academy of Proctology held March 23 to 26 in New York. Dr. Solow, chairman of the Massachusetts chapter of the International Academy of Proctology, was moderator of the panel discussion, which was on "Ulcerative Colitis." Dr. Brown discussed surgical aspects, and Dr. Lowell, medical aspects of the disease.

Woman's Medical College

"Problems of Adoption" was the subject of a panel discussion on April 18, 1955, sponsored by the Department of Preventive Medicine. One of the discussants was DR. KATHERINE BAIN, U.S. Children's Bureau.

DR. MOLLIE A. GEISS, professor of pathology since 1945, has resigned her post after 33 years of service on the faculty.

NEW YORK. DR. GRACE MCLEAN ABBATE has been appointed a member of the Mental Hygiene Board of the City of New York.

DR. MARCELLE BERNARD has participated in the Cana Conferences sponsored by the Family Service Department of Catholic Charities. Her topic was "The Catholic Doctor Looks at Marriage." She also participated in a panel discussion "Preparation for the Medical Profession" at Fordham University.

DR. LEONI N. CLAMAN, a Fellow of the American Academy of Allergy, is now secretary of the New York Allergy Society.

DR. SOPHIA KLEEGMAN, president of the New York Women's Association from 1942 to 1944, is a director of the New York State Planned Parenthood League and also a member of the board of directors of the National Committee for Maternal Health.

DR. GERALDINE PETERSON-KRAG has written a book entitled "Personality Factors in Work and Employment" published in January 1955 by Funk & Wagnalls.

DR. ADELAIDE ROMAINE has been appointed chairman of a reference committee of the New York State Medical Society. She has also been elected a director of the Cornell Medical College Alumni Association.

DR. THERESA SCANLAN is an alternate delegate of the New York County Medical Society to the New York State Medical Society Convention.

DR. MARGUERITE P. SYKES, research fellow of Sloan-Kettering Institute, presented a paper in San Francisco at the meeting of the American Association for Cancer Research.

DR. MARIE PICHEL WARNER's article "Artificial Insemination in Cases of Incurable Sterility" has been included in a volume published by the Society of Medical Jurisprudence of papers delivered before them between 1942 and 1950.

General

DR. ENID K. RUTLEDGE is secretary of the Denver Subsidiary Board of the National Board of Medical Examiners, while DR. ALMA DEA MORANI is secretary of the Philadelphia Subsidiary Board.

DR. EILEEN NIEDFIELD (Sister M. Frederic of the Medical Mission Sisters of Philadelphia) sailed for India in April to begin medical missionary work at a 150 bed hospital in Mandar in the Bihar district of India. After her internship at St. Michael's Hospital in Newark, New Jersey, Dr. Niedfield had a surgical residency at Georgetown University Hospital and received a Master of Science in Surgery degree in 1954. She will join DR. RUTH TAGGART, a Woman's Medical College of Pennsylvania graduate, who is superintendent of Holy Family Hospital, Mandar. The Medical Mission Sisters, the organization to which these two doctors belong, is a religious community devoted to the care of the sick in the missions. They staff 11 hospitals in the Indian sub-continent.

The Sisters also work in Africa, Indonesia, and South America. Another member of this group, DR. KATHRYN JOBSON (Sister M. Christine), just completed a residency at St. Joseph's Hospital, San Francisco, California, and has recently been assigned to the community's hospital in South India.

DR. EDITH L. POTTER, of the Department of Obstetrics and Gynecology, University of Chicago, was guest speaker at a meeting of the Sedgwick County Society held at Wichita, Kansas. Her subject was "Erythroblastosis Fetalis." In the afternoon she conducted an informal clinic at Wesley Hospital with Dr. Edward X. Crowley as moderator.

On May 4, the Union County (New Jersey) Heart Association presented a cardiological symposium entitled, "Structural Defects of the Heart."

Dr. Helen Taussig of Baltimore discussed "Congenital Defects."

The Missouri Society of Medical Technologists met in Municipal Auditorium, Kansas City. One of the guest speakers was Dr. Priscilla White of Boston who discussed the subject "Blood Sugar Determinations."

The one hundred twentieth annual meeting of the Tennessee State Medical Society was held in Chattanooga. At the pediatrics meeting, Dr. Katharine Dodd of Little Rock, Arkansas, was one of the guest speakers.

International

Great Britain. Dr. Patricia M. Elliot was elected representative on the Standing Committee of Convocation of the Faculty of Medicine of the University of London for a period of three years.

Dr. Dorothea B. I. Halstead has been appointed consultant anesthetist at Hounslow Hospital and Dr. Betty E. Powe has been appointed admissions officer at Central Middlesex Hospital.

Ireland. A recent meeting of the Medical Women's Federation (North of Ireland) was held at the Pathological Theatre, Grosvenor Road. Films were shown of the development of a fetus from conception to birth, as well as a film, "A Brother for Susan," which prepares a child for the coming of a new baby.

Pan American Medical Woman's Alliance

The next Congress of the Pan American Medical Woman's Alliance will be held in Santiago, Chile, March 6 to 13, 1956. Dr. Erna Mahn, vice-president of the Chilean branch of the PAMWA, has prepared a tentative scientific program.

Scientific papers are to be contributed by doctors of North, South, and Central America, and translated into both English and Spanish. Dr. Eva Cutright of Wooster, Ohio, is planning the North American part of the program.

A tour is planned, starting in Mexico City, February 18, 1956, and short stops will be made in San Salvador and Panama, with a week's tour through the Chilean lake regions of Southern Chile before the Congress. A group of Chilean doctors will serve as hostesses and guides.

The return trip from Chile will include a week's visit with Bolivian colleagues in La Paz, who are planning trips into the interior. Four days are being scheduled for Cuzco and Machu Picchu, Lost City of the Incas, and a short stop in Lima. On March 28, the tour group will return to the States.

THESE WERE THE FIRST

Dr. Eva Dodge, graduate of the Maryland School of Medicine, was the first woman resident of the University of Maryland Hospital where she interned. Noted as an educator and organizer, Dr. Dodge was named Little Rock's "Woman of the Year" in 1952, and is assistant professor of obstetrics and gynecology at the University of Arkansas Medical School. After teaching at the Woman's Medical College in Shanghai, China, and study abroad, Dr. Dodge organized maternal care units in the state of Alabama before going to the University of Arkansas in 1945.

Dr. Policarpio Pardo-Catalina, graduate in medicine of the University of the Philippines, was a pensionado to the Harvard Medical School in 1928, the first Filipino woman psychiatrist. After study in America and in Europe, she spent seven years with the Insular Psychopathic Hospital in Mandaluyong, and in 1925 served on the staff of the San Lazaro Hospital to which she returned in 1937.

Dr. Helen Reynolds Kellogg, graduate in 1886, of Northwestern University, Woman's Medical College, Chicago, was a pioneer in social welfare, founder of a free dispensary for girls in Chicago, and one of the directors of the Klio Noonday Rest Association. Dr. Kellogg was known for her many works of philanthropy.

Dr. Bernadino Consuelo of Trujillo Cotu, Dominican Republic, studied at the Woman's Medical College of Pennsylvania and at the Johns Hopkins School of Medicine. She was appointed by the President of Trujillo as chief of the department of gynecology of Padre Billini Hospital, the first woman in charge of that department; she served as assistant professor at the University of Santo Domingo; and was professor of gynecology, the first woman professor in that university.

Dr. Consuelo Vadillo, was the first woman in Yucatan to receive a medical degree. She studied in 1934-1935 at the Woman's Medical College of Pennsylvania and returned to practice in Merida. She transformed her own home into a clinic for the treatment of country women and lectured widely on health education. In 1940, Dr. Vadillo went to Mexico City to carry on work in gynecology and cancer prevention.

—Elizabeth Bass, M.D.

Letters TO THE EDITOR

"We had a wonderful Christmas season with a delightful program given by the staff. Our White Christmas Offering was over RS.200. This offering goes to our W.S.C.S. and part of it will go to the Nepal Mission work in which our church has a real part. We had village celebrations in six of the villages near Kolar. The lovely Christmas cards, the booklets of Christmas cards and scrapbooks, a piece of cloth for each child and each adult made the occasion in the villages very festive. A mixture of dry puffed rice and peanuts is a favourite eatable on such occasions. We take it to the villages in a big burlap bag and give it out by the cupful as one after another comes holding a little part of a shirt or a jacket to receive it. If the shirt or jacket, the only clothing a child may have on, is too small he will take it off and collect his puffed rice in it and then sit down naked to eat. After eating he puts on the jacket.

"For our students and staff, we had breakfast in the School of Nursing on Christmas morning and we were ready for church service at 8:30 a.m. Carolling took place all through the wards the night before Christmas and the Christmas story was told in various languages in each ward.

"Shortly after Christmas, our children's ward extension was ready for occupancy. It was dedicated on January 8; and since then we have had so many children in it that we have wondered why it was not built twice the size. It is just an addition to the two rooms that had been used as a children's ward. It now accommodates 24 children, but they are crowded especially when one member of the family, usually the mother, stays with each child. One of the greatest problems is to keep the children in bed at nights, for the mothers like to take their sick children out of bed and have them sleep on the floor. We are trying to figure ways and means to have children without their parents. It is so much easier to treat them in that way. They respond so much better. But our children come from long distance many times and the mothers have no other place to stay.

"Almost at the same time as the children's ward was opened, the extension for our operating room was ready for use, and for the first time in the 45 year history of the hospital, we began to scrub for operations with running water. We have two lovely sinks. The running water is supplied from a tank on the roof which is filled by hand when there is not sufficient water to pump the water up. There is also space for keeping supplies and for sterilizing. It is wonderful. We can't imagine how we existed before in the very cramped quarters.

"On Jan. 25, Miss Slotemaker, a friend of Dr. Huitema from Holland, arrived on her way to Indonesia. She wanted to spend time in India to visit ashrams and training centers for Christian workers. We had a lovely day with her before she started on her program and we started on a trip to the north. I had to attend a Methodist medical council meeting in Delhi, and that gave opportunity for us to visit other places in north India which Dr. Huitema had not seen before and which I had not seen for some years. It was a privilege to be at the Capital on Republic Day, Jan. 26, to see the parade. We were glad to visit Ludhiana Christian Medical College which is struggling in every possible way to attain the standard for recognition for a higher degree. One of their graduates is on our staff now and another one is coming in July. After the medical council meeting we visited Simla, Vrindaban, Mathura, Bareilly, Lucknow, Benares, Allahabad, Jabalpur, and then spent two days in Bombay with Mr. and Mrs. Heins. It was very cold in the north. I was glad to get back to a warm area. Wherever we go, we are proud of our graduate nurses and the reports we hear of their work.

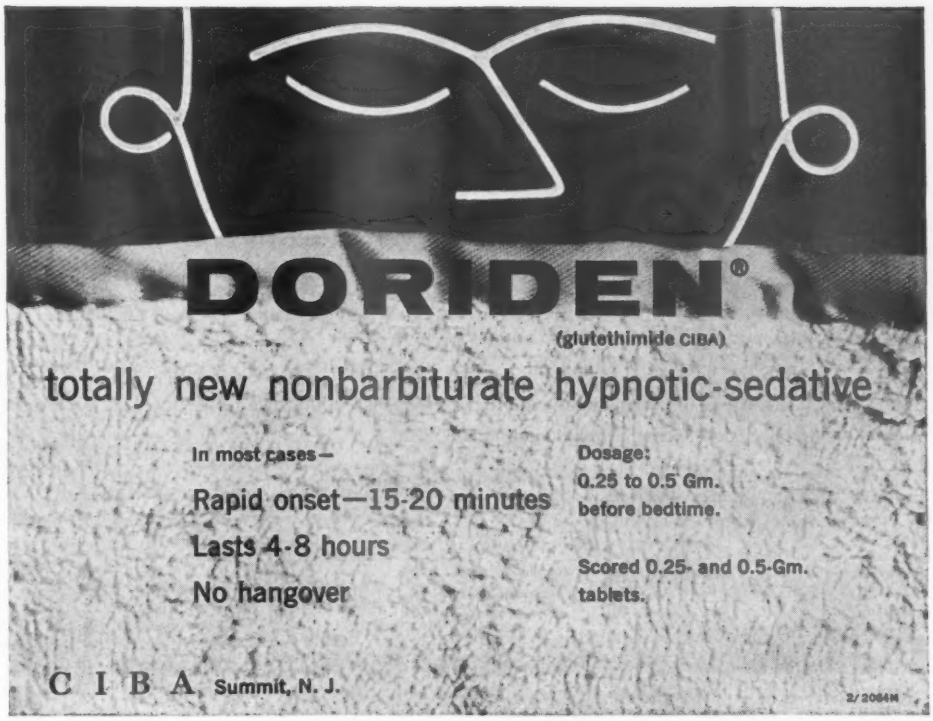
"Yesterday we had 156 inpatients and more than 230 outpatients besides a very large crowd that comes for UNICEF milk every morning. One patient with less than 10 percent hemoglobin after the birth of her baby in her village has now gone up to 44 percent after four blood transfusions. Her people feel that she is so much better that they want to take her home. We are urging them to let her stay a little longer. We are beginning to have more typhoid patients just now and we have three plague patients in the hospital. This is unusual. The Public Health Department is working on it in the villages and our health nurses have been busy inoculating everyone. Gnanamonie Paulraj, after six months in Bidar as nursing superintendent, has now come back to our staff in charge of public health nursing.

"Your cards, gifts, and messages at Christmas time have all been greatly appreciated. Some I have had opportunity to answer and others are still unanswered. Please accept this message as my personal 'thank you' and also a 'thank you' from our staff and student group here. Our U.S.A. friends mean much to all of us. We keep praying for you and appreciate your prayers for us.

"With love and gratitude always,

—ESTHER SHOEMAKER, M.D."

March 10, 1955
Ellen T. Cowen Memorial Hospital
Kolar, India



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EDITORIAL FORECAST

August 1955

Dr. Eva R. Sargent is the Guest Editor for the special Branch Four, New Jersey, issue of the JOURNAL to appear in August. A variety of articles will be presented and information about medical women of New Jersey.

"Common Dermatoses in the Geriatric Patient," by Eva T. Brodkin, M.D.

"The Neoplastic Infections of Men and Animals," by Virginia Wuerthele-Caspé, M.D. Dr. Wuerthele-Caspé, formerly of New Jersey, is now living in California.

"The Physician's Responsibility in Mental Retardation," by Amy S. Barton-Blatt, M.D.

"Health Objectives in India," by Katherine Kuder, M.D.

"The Industrial Physician and Workmen's Compensation," by Emma Dowling Kyhos, M.D. This is one of four papers presented in a symposium on Industrial Medicine at the Annual Meeting of the American Medical Women's Association, June 4, 1955.

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Graduate study.....Further degrees.....
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Organizations to which you belong.....Dates.....
Offices held.....
Institutions with which you are, or have been associated.....
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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

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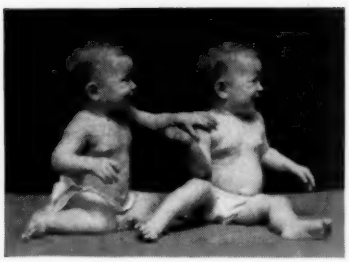

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